# Filing at a Glance

| | |
|---|---|
| Company: | Dentegra Insurance Company |
| Product Name: | DIC, HCR Ind PPO TN, forms and rates |
| State: | Tennessee |
| TOI: | H10I Individual Health - Dental |
| Sub-TOI: | H10I.000 Health - Dental |
| Filing Type: | Form/Rate |
| Date Submitted: | 06/14/2013 |
| SERFF Tr Num: | DDPA-129064431 |
| SERFF Status: | Assigned |
| State Tr Num: | H-130880 |
| State Status: | Assigned - Pending Review |
| Co Tr Num: | DIC, HCR IND PPO TN, FORMS AND RATES |
| Implementation Date Requested: | |
| Author(s): | Connie Roth, Sharon Ford, Cassandra Fiorito |
| Reviewer(s): | Vicky Stotzer (primary), Brian Hoffmeister, Melissa Merritt |
| Disposition Date: | |
| Disposition Status: | |
| Implementation Date: | |

State Filing Description:
I HIX DEN P
PIP-TN-DIC
individual exchange dental policies

**State:** Tennessee **Filing Company:** Dentegra Insurance Company
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental
**Product Name:** DIC, HCR Ind PPO TN, forms and rates
**Project Name/Number:** /

## General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Deemer Date:
Submitted By: Sharon Ford

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: These forms will not be used in our domiciliary state of Delaware; therefore, they have not been submitted to the Delaware Department of Insurance.
Market Type: Individual
Individual Market Type:
Filing Status Changed: 06/17/2013
State Status Changed: 06/17/2013
Created By: Sharon Ford
Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval are new individual dental forms PIP-TN-DIC et al. The primary form number is PIP-TN-DIC. A complete listing of the forms included in this filing and the forms with which they are used is included at the end of this letter/section.

These forms do not replace any forms on file with your Department. The forms will be used when our Dental PPO product is sold direct or by a partnership relationship to individuals inside the Tennessee Health Benefit Exchange. If required by the Tennessee Health Benefit Exchange, we will file substantially similar plans for outside the Exchange. These products will use the Dentegra Dental networks and will be marketed by the Tennessee Health Benefit Exchange, licensed agents, brokers, third party administrators, mass marketed via various publications or online.

These plans provide the coverage for: the pediatric oral services required by the essential health benefits ('EHB') provisions; and for adult dental services ('Sup') required by the Affordable Care Act ('ACA'):
• Individual Pediatric and Supplemental High and Low Plans

Our effective date for use of these forms will be October 2013 when the Exchange is opened for business for coverage effective January 1, 2014, provided the filing has been approved by or deemed approved by your Department.

Text and numerical data in [brackets] is variable. Enclosed for your information are Variable Exhibits of these forms with comments for the variability. The comments explain what is variable and the various options that could be used. Any change or modification to a variable item outside the approved ranges will be submitted for prior approval.

Forms are:

Dental Individual Pediatric High and Low Plans
PIP-TN-DIC Policy

The following forms will be used with PIP-TN-DIC
PIAtAhi-TN-DIC Attachment A (Deductibles, Maximums and Contract Benefit Levels) – High Plan
PIAtAlo-TN-DIC Attachment A (Deductibles, Maximums and Contract Benefit Levels) – Low Plan
PIAtB-TN-DIC Attachment B (Services, Limitations and Exclusions)
PIAtB1-DIC Attachment B-1 (Schedule of Covered Services)

**State:** *Tennessee* **Filing Company:** *Dentegra Insurance Company*
**TOI/Sub-TOI:** *H10I Individual Health - Dental/H10I.000 Health - Dental*
**Product Name:** *DIC, HCR Ind PPO TN, forms and rates*
**Project Name/Number:** */*

Individual EHB and Supplemental High and Low Plans

XIP-TN-DIC Policy

The following forms will be used with XIP-TN-DIC

XIAtAhi-TN-DIC Attachment A (EHB Deductibles, Maximums and Contract Benefit Levels) – High Plan
XIAtAlo-TN-DIC Attachment A (EHB Deductibles, Maximums and Contract Benefit Levels) – Low Plan
XIAtB-TN-DIC Attachment B (EHB Services, Limitations and Exclusions)
XIAtB1-DIC Attachment B-1 (EHB Schedule of Covered Services)
XIAtChi-TN-DIC Attachment C (Sup Deductibles, Maximums and Contract Benefit Levels) – High Plan
XIAtClo-TN-DIC Attachment C (Sup Deductibles, Maximums and Contract Benefit Levels) – Low Plan
XIAtDhi-TN-DIC Attachment D (Sup Services, Limitations and Exclusions)- High Plan
XIAtDlo-TN-DIC Attachment D (Sup Services, Limitations and Exclusions)- Low Plan

Thank you for your attention to this filing. If you should need any additional information or have any questions, please do not hesitate to contact me at sford@dentegra.com or (770)641-5370.

## Company and Contact

### Filing Contact Information

Sharon Ford(Dentegra), Regulatory Analyst sford@dentegra.com
1130 Sanctuary Parkway, Ste 600 770-641-5370 [Phone]
Alpharetta, GA 30009 770-641-5193 [FAX]

### Filing Company Information

Dentegra Insurance Company
100 First Street
San Francisco, CA 94105
(866) 714-7730 ext. [Phone]

CoCode: 73474
Group Code: 2479
Group Name: Dentegra Group, Inc.
FEIN Number: 75-1233841

State of Domicile: Delaware
Company Type: LAH
State ID Number:

## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $700.00 |
| Retaliatory? | Yes |
| Fee Explanation: | Domiciliary Fee for Delaware is $50.00 ($50.00 x 14 = $700.00) |
| Per Company: | No |

| Company | Amount | Date Processed | Transaction # |
|---|---|---|---|
| Dentegra Insurance Company | $700.00 | 06/14/2013 | 71156502 |

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|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *DDPA-129064431* | ***State Tracking #:*** | *H-130880* | ***Company Tracking #:*** | *DIC, HCR IND PPO TN, FORMS AND RATES* |

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|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *Dentegra Insurance Company* |
| ***TOI/Sub-TOI:*** | *H10I Individual Health - Dental/H10I.000 Health - Dental* | | |
| ***Product Name:*** | *DIC, HCR Ind PPO TN, forms and rates* | | |
| ***Project Name/Number:*** | */* | | |

# Form Schedule

**Lead Form Number: PIP-TN-DIC**

| Item No. | Schedule Item Status | Form Name | Form Number | Form Type | Form Action | Action Specific Data | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|
| 1 | | PPO Individual Pediatric Dental Policy | PIP-TN-DIC | POL | Initial | | 53.100 | PIP-TN-DIC (Clean 6-5-13).pdf |
| 2 | | PPO Individual Pediatric Dental Attachment A (Deductibles, Maximums and Contract Benefit Levels) – High Plan | PIAtAhi-TN-DIC | OUT | Initial | | 64.000 | PIAtAhi-TN-DIC (Clean 6-11-13).pdf |
| 3 | | PPO Individual Pediatric Dental Attachment A (Deductibles, Maximums and Contract Benefit Levels) – Low Plan | PIAtAlo-TN-DIC | OTH | Initial | | 67.300 | PIAtAlo-TN-DIC (Clean 6-11-13).pdf |
| 4 | | PPO Individual Pediatric Dental Attachment B (Services, Limitations and Exclusions) | PIAtB-TN-DIC | OTH | Initial | | 54.500 | PIAtB-TN-DIC (Clean 6-5-13).pdf |

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|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *DDPA-129064431* | ***State Tracking #:*** | *H-130880* | ***Company Tracking #:*** | *DIC, HCR IND PPO TN, FORMS AND RATES* |

| | | | |
|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *Dentegra Insurance Company* |
| ***TOI/Sub-TOI:*** | *H10I Individual Health - Dental/H10I.000 Health - Dental* | | |
| ***Product Name:*** | *DIC, HCR Ind PPO TN, forms and rates* | | |
| ***Project Name/Number:*** | */* | | |

**Lead Form Number: PIP-TN-DIC**

| Item No. | Schedule Item Status | Form Name | Form Number | Form Type | Form Action | Action Specific Data | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|
| 5 | | PPO Individual Pediatric Dental Attachment B-1 (Schedule of Covered Services) | PIAtB1-TN-DIC | OTH | Initial | | 54.300 | PIAtB1-DIC.pdf |
| 6 | | PPO Individual Combined/Integrated EHB and Sup Dental Policy | XIP-TN-DIC | POL | Initial | | 51.500 | XIP-TN-DIC (Clean 6-11-13).pdf |
| 7 | | PPO Individual Combined Attachment A (EHB Deductibles, Maximums and Contract Benefit Levels) – High Plan | XIAtAhi-TN-DIC | OTH | Initial | | 61.100 | XIAtAhi-TN-DIC (Clean 6-11-13).pdf |
| 8 | | PPO Individual Combined Attachment A (EHB Deductibles, Maximums and Contract Benefit Levels) – Low Plan | XIAtAlo-TN-DIC | OTH | Initial | | 61.100 | XIAtAlo-TN-DIC (Clean 6-11-13).pdf |
| 9 | | PPO Individual Combined Attachment B (EHB Services, Limitations and Exclusions) | XIAtB-TN-DIC | OTH | Initial | | 50.400 | XIAtB-TN-DIC (Clean 6-11-13).pdf |

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|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *DDPA-129064431* | ***State Tracking #:*** | *H-130880* | ***Company Tracking #:*** | *DIC, HCR IND PPO TN, FORMS AND RATES* |

| | | | |
|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *Dentegra Insurance Company* |
| ***TOI/Sub-TOI:*** | *H10I Individual Health - Dental/H10I.000 Health - Dental* | | |
| ***Product Name:*** | *DIC, HCR Ind PPO TN, forms and rates* | | |
| ***Project Name/Number:*** | */* | | |

**Lead Form Number: PIP-TN-DIC**

| Item No. | Schedule Item Status | Form Name | Form Number | Form Type | Form Action | Action Specific Data | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|
| 10 | | PPO Individual Combined Attachment B-1 (EHB Schedule of Covered Services and Limitations) | XIAtB1-DIC | OTH | Initial | | 54.300 | XIAtB1-DIC.pdf |
| 11 | | PPO Individual Combined Attachment C (Sup Deductibles, Maximums and Contract Benefit Levels) - High Plan | XIAtChi-TN-DIC | OTH | Initial | | 52.800 | XIAtChi-TN-DIC (Clean 6-11-13)pdf.pdf |
| 12 | | PPO Individual Combined Attachment C (Sup Deductibles, Maximums and Contract Benefit Levels) - Low Plan | XIAtClo-TN-DIC | OTH | Initial | | 52.800 | XIAtClo-TN-DIC (Clean 6-11-13).pdf |
| 13 | | PPO Individual Combined Attachment D (Sup Services, Limitations and Exclusions) High Plan | XIAtDhi-TN-DIC | OTH | Initial | | 50.400 | XIAtDhi-TN-DIC (Clean 6-11-13).pdf |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *DDPA-129064431* | ***State Tracking #:*** | *H-130880* | ***Company Tracking #:*** | *DIC, HCR IND PPO TN, FORMS AND RATES* |

| | | | |
|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *Dentegra Insurance Company* |
| ***TOI/Sub-TOI:*** | *H10I Individual Health - Dental/H10I.000 Health - Dental* | | |
| ***Product Name:*** | *DIC, HCR Ind PPO TN, forms and rates* | | |
| ***Project Name/Number:*** | */* | | |

**Lead Form Number: PIP-TN-DIC**

| Item No. | Schedule Item Status | Form Name | Form Number | Form Type | Form Action | Action Specific Data | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|
| 14 | | PPO Individual Combined Attachment D (Sup Services, Limitations and Exclusions) Low Plan | XIAtDlo-TN-DIC | OTH | Initial | | 50.400 | XIAtDlo-TN-DIC (Clean 6-11-13).pdf |

**Form Type Legend:**

| | | | |
|---|---|---|---|
| **ADV** | Advertising | **AEF** | Application/Enrollment Form |
| **CER** | Certificate | **CERA** | Certificate Amendment, Insert Page, Endorsement or Rider |
| **DDP** | Data/Declaration Pages | **FND** | Funding Agreement (Annuity, Individual and Group) |
| **MTX** | Matrix | **NOC** | Notice of Coverage |
| **OTH** | Other | **OUT** | Outline of Coverage |
| **PJK** | Policy Jacket | **POL** | Policy/Contract/Fraternal Certificate |
| **POLA** | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | **SCH** | Schedule Pages |

[State logo[D1]]


# Dentegra® Dental PPO

## Children's [Plan 70/Plan 85[D2]]

Combined Policy and Disclosure Form

Provided by:

Dentegra Insurance Company

variable text - highlight & delete if not needed
variable text - highlight & delete if not needed

**This Policy is conditionally renewable and may be terminated if all policies in this state are terminated.**

[dentegra[D3].com]

[State website and phone number[D4]]

# Policy

Your dental plan is underwritten by Dentegra® Insurance Company ("Dentegra") and administered by Delta Dental Insurance Company. Dentegra will pay Benefits for covered dental services as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first installment of Premium. It takes effect on the Effective Date shown on Attachment A Benefits Summary ("Attachment A") attached to this Policy. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where you live.

**READ YOUR POLICY AND ATTACHMENTS CAREFULLY**

**Ten (10)-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY**

Please read this Policy. If this Policy was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements or if you are not satisfied for any reason, you may return the Policy within ten (10) days after its delivery. Mail or deliver it to Dentegra's home office or to the agent through whom you purchased it. Any Premium paid will be refunded. This Policy will then be void from its start.

This Policy is signed for Dentegra, as of its Effective Date by:

Anthony S. Barth, Vice Chairman

## Table of Contents

# INTRODUCTION

We are pleased to welcome you to this individual Dentegra PPO dental plan. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

**NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.**

## Using This Policy

This Policy discloses the terms and conditions of the coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that "you" and "your" mean the Enrollees who are covered under this Policy. "We", "us" and "our" always refer to Dentegra.

## Contact Us

If you have any questions about your coverage that are not answered here, please visit our website at [dentegra[D5].com] or call our Customer Service Center. A Customer Service representative can answer questions you may have about obtaining dental care, help you locate a Dentegra Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at [877[D6]-280-4204] to obtain information about Enrollee Benefits, claim status or to speak to a Customer Service representative for assistance. If you prefer to write to us with your question(s) please mail your inquiry to the following address:

Dentegra Insurance Company
[[SF7]P.O. Box 1850
Alpharetta, GA 30023-1850]

## Identification Number

Please provide the Enrollee's ID number to your Provider whenever you receive dental services. The Enrollee ID number should be included on all claims submitted for payment. Identification cards are not required, but if you wish to have one you may obtain one by visiting our website at [dentegra.com].

## DEFINITIONS

The following are definitions of words that have special or technical meanings under this Policy.

**Accepted Fee:** the amount the attending Provider agrees to accept as payment in full for services rendered.

**Benefits (In-Network or Out-of-Network)**: the amounts that Dentegra will pay for dental services under this Policy. In-Network Benefits are those covered by this Policy and performed by a Dentegra Provider. Out-of-Network Benefits are those covered by this Policy a Non-Dentegra Provider.

**Benefit Year/Calendar Year:** the 12 months of the year from January 1 through December 31.

**Claim Form:** the standard form used to file a claim, request Pre-Treatment Estimate or request Prior Authorization for medically necessary orthodontics.

**Deductible:** a dollar amount that a Pediatric Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits.

**Dentegra PPO℠ Provider (Dentegra Provider):** a Provider who contracts with Dentegra and agrees to accept the Dentegra Provider's Contracted Fees as payment in full for services provided under this PPO plan.

**Dentegra PPO Provider's Contracted Fee (Dentegra Provider's Contracted Fee):** the fee for each Single Procedure that Dentegra Providers have contractually agreed to accept as payment in full for treating Enrollees.

**Effective Date**: The original date the plan starts. This date is given in Attachment A.

**Eligible Pediatric Enrollee**: a person who is considered to be a Qualified Individual by the Tennessee Federally Facilitated Marketplace Exchange and is eligible for Benefits as described in this Policy.

**Exchange**: Tennessee Federally Facilitated Marketplace Exchange.

**Maximum Contract Allowance:** the reimbursement under the Enrollee's benefit plan against which Dentegra calculates its payment and the financial obligation for the Enrollee. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by Dentegra Providers is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee; or
- by a Non-Dentegra Provider is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee for a Dentegra Provider in the same geographic area.

**Non-Dentegra Provider:** a Provider who is not a Dentegra Provider and has not agreed to accept the Dentegra Provider's Contracted Fees.

**Open Enrollment Period:** the period of the year that the Exchange has established when the Responsible Party may change coverage selections for the next Contract Year.

**Out-of-Pocket Maximum:** the maximum amount that a Pediatric Enrollee must satisfy for covered dental services during the Calendar Year provided a Dentegra Provider is used. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Provider even after the Out-of-Pocket Maximum has been met. The Out-of-Pocket Maximum for Dentegra Providers is shown in Attachment A.

**Patient Pays:** the financial obligation for a Pediatric Enrollee for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

**Pediatric Enrollee:** an Eligible Pediatric Enrollee enrolled to receive Benefits; may also be referred to as "Enrollee".

**Policy:** means this agreement between Dentegra and the Responsible Party including any application supplied by Tennessee Federally Facilitated Marketplace Exchange, any attached amendments and appendices. This Policy constitutes the entire agreement between the parties.

**Policy Benefit Level:** the percentage of Maximum Contract Allowance that Dentegra will pay before the Out-of-Pocket Maximum has been satisfied.

**Policy Term:** the period during which this Policy is in effect.

**Policy Year:** the 12 months starting on January 1st and each subsequent 12 month period thereafter coinciding with the Benefit Year. Policy Year can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change.

**Premium:** the amount payable as provided in Attachment A.

**Pre-Treatment Estimate:** an estimation of the allowable Benefits under this Policy for the services proposed, assuming the person is an eligible Enrollee.

**Procedure Code:** the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

**Program Allowance:** the amount determined by a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program allowances may differ based on the Provider's contracting status.

**Provider:** a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

**Qualified Individual:** an individual determined by Tennessee Federally Facilitated Marketplace Exchange to be eligible to enroll through the Exchange.

**Qualifying Status Change:** a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- dependent child ceases to satisfy eligibility requirements;
- a court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by the Exchange.

**Responsible Party**: the person who enrolls an Eligible Pediatric Enrollee for Benefits.

**Single Procedure**: a dental procedure that is assigned a separate Procedure Code.

**Spouse**: a person related to or a partner of the Responsible Party:

- as defined and as may be required to be treated as a Spouse by the laws of the state where this Policy is issued and delivered; or
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Responsible Party resides.

**Submitted Fee:** the amount that the Provider bills and enters on a claim for a specific procedure.

# ELIGIBILITY AND ENROLLMENT

## Eligibility Requirement

Eligible Pediatric Enrollees are Qualified Individuals as determined by the Exchange. A Qualified Individual must satisfy the Exchange's requirements regarding:

- Citizenship, status as a national, or otherwise lawfully present in the United States;
- Incarceration;
- Residency.

Eligible Pediatric Enrollees can be:

Responsible Party's dependent children from birth to age 26 and include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of Spouse. Adopted children are eligible from the date of entry into the adoptive home or filing of the petition for adoption, whichever occurs first. If the child is in the custody of the state, coverage will begin at the date of entry of a final decree of adoption. Coverage for an adopted child will continue unless the petition is denied.

## Enrollment Grace Period

There is a period of 10 days from the Pediatric Enrollee's coverage Effective Date during which the Responsible Party may rescind this Policy and receive a full refund, provided the Pediatric Enrollee has not used Benefits under this Policy.

## RENEWABLE - PREMIUM MAY CHANGE CONDITIONALLY:

The rate of the monthly Premiums will not be increased during the initial Policy Year.

The Responsible Party will receive renewal information from the Exchange prior to any applicable open enrollment period. Provided Dentegra continues to make this policy available through the Exchange at the renewal period:

- the Responsible Party may elect to choose this Contract on behalf of Eligible Pediatric Enrollees, subject to the applicable Premium through the Exchange for this plan at the time of renewal; and

- The Responsible Party may not have to make an election through the Exchange in subsequent open enrollment periods to continue coverage for Eligible Pediatric Enrollees. The Responsible Party should refer to the Exchange rules regarding automatic renewal of coverage.

## Termination of Coverage

The Enrollee and/or Responsible Party have the right to terminate coverage under this Policy by sending Dentegra or the Exchange written notice of intent to terminate this Policy. The effective date of a requested termination will be fourteen days from the date of Dentegra's receipt of the request for termination. If coverage is termed because the Pediatric Enrollee is covered by Medicaid, the last day of coverage with Dentegra is the day before the new coverage is effective.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date.

The Responsible Party may keep this Policy in force by timely payment of the Premiums. However, Dentegra may terminate coverage due to:

- Enrollee no longer eligible through the Exchange;
  - if termination is due to loss of eligibility through the Exchange, termination is effective the last day of the month following the month that the Exchange notifies you of lack of eligibility;
- non-payment of Premium:
  - if Premiums are not received by the 90th day of the Premium grace period, your policy will be terminated as of the 31st day of the Premium grace period. See *Grace Period on Late Payments*.
- Fraud or material misrepresentation made by or with the knowledge of the Responsible Party or the Enrollee applying for this coverage or filing a claim for benefits;
- Enrollee has reached the age of 26;
- the Responsible Party changes to a new pediatric dental policy for Enrollees through Tennessee Federally Facilitated Marketplace Exchange; or
- Dentegra ceasing to renew all Policies issued on this form to residents of the state where you live.

## Reinstatement

If you do not pay the Premium within the time granted for payment, the Policy will be terminated as of the 31st day of the Premium grace period. See *Grace Period on Late Payments*.

If the Policy is terminated you may re-enroll in the program at the next Open Enrollment Period and the deductible and maximum applicable to your program will start over. However, the Policy may be reinstated with no break in coverage provided the full Premium due is received by us within 90 days of the date of the past due Premium. The reinstated Policy will have the same rights as before your Policy lapsed, unless a change is made to the Policy in connection with the reinstatement. These changes, if any, will be sent to you for you to attach to the Policy.

# OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how this dental plan works and how to make it work best for you.

## Benefits, Limitations and Exclusions

We will pay Benefits for the types of dental services as described in Attachment B Services, Limitations and Exclusions ("Attachment B") and Attachment B-1 Schedule of Covered Services and Limitations ("Attachment B-1").

We will pay Benefits only for covered services. This Policy covers several categories of Benefits when a Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims shall be processed in accordance with our standard processing policies. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under this Policy. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

## Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown in the Attachment A, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled "Selecting Your Provider"). Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select Dentegra Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the sections titled "Selecting Your Provider" for more information.

## Deductible

A deductible ("Deductible") is an amount the Responsible Party must pay out-of-pocket before Benefits are paid. The Deductible amounts, if any, are listed in Attachment A. Deductibles apply to all covered dental services unless otherwise noted. Only the Provider's fees paid for covered Benefits will count toward the Deductible.

## Prior Authorization for Medically Necessary Orthodontics

Orthodontic treatment is covered only when medically necessary as evidenced by a severe handicapping malocclusion, and prior authorization ("Prior Authorization") is required. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

## Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under this Policy for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before the Pediatric Enrollee receives any prescribed treatment, you will have an estimate up front of what we will pay and the difference is the financial obligation of the Responsible Party. The Benefits will be processed according to the terms of this Policy when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

1) the date this Policy terminates;
2) the date the Enrollee's coverage ends; or
3) the date the Provider's agreement with Dentegra ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are covered and meet all the requirements of the plan at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

# SELECTING YOUR PROVIDER

## Free Choice of Provider

We recognize that many factors affect the choice of Provider and therefore support your right to freedom of choice regarding your Provider. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may

see any Provider for your covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider.

**Remember, you enjoy the greatest benefits—including out-of-pocket savings—when you choose a Dentegra Provider.** To take full advantage of your Benefits, we highly recommend you verify a dentist's participation status with Dentegra with your dental office before each appointment. Review this section for an explanation of Dentegra payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

## Locating a Dentegra Provider

You may access information through our website at dentegra.com. You may also call our Customer Service Center and one of our representatives will assist you. We can provide you with information regarding a Provider's network, specialty and office location.

## Choosing a Dentegra Provider

Selecting a Dentegra Provider potentially allows the greatest reduction in Pediatric Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon. Also, the services received from a Dentegra Provider apply towards the Out-of-Pocket Maximum limiting a Pediatric Enrollee's out-of-pocket costs to the amount shown in Attachment A.

## Choosing a Non-Dentegra Provider

If a Provider is a Non-Dentegra Provider, the amount charged may be above that accepted by the Dentegra Providers, and Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply after the Out-of-Pocket Maximum is met. Costs incurred with a Non-Dentegra Provider do not count towards the Out-of-Pocket maximum. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

## Additional Obligations of Dentegra Providers:

- The Dentegra Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Dentegra after satisfaction of the Deductible and Coinsurance, and the Pediatric Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.

- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra PPO Provider's Contracted Fees.

## How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form, which most dental offices have available. Dentegra Providers will fill out and submit your claims paperwork for you. Some Non-Dentegra Providers may also provide this service upon your request. If you receive services from a Non-Dentegra Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Claim Form" for more information.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Dentegra Insurance Company

[P.O. Box 1850

Alpharetta, GA 30023-1850]

## Payment Guidelines

We do not pay Dentegra Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider files a claim for services more than 15 months after the date you received the services, payment may be denied. If the services were received from a Non-Dentegra Provider, you are still responsible for the full cost. If the payment is denied because your Dentegra Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your Dentegra Provider that you were covered under a Dentegra Policy at the time you received the service, you may be responsible for the cost of that service.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, please contact us.

# PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment, and any subsidy you receive, if applicable. Premiums are listed on Attachment A. An Eligible Enrollee is responsible for making Premium payments, paying Deductibles and Coinsurance and ensuring the Provider is aware of any other dental coverage he/she carries. Each Premium is to be paid on or before its due date. A due date is the day following the last day of the period for which the preceding Premium was paid.

You may pay your Premium by visiting our website at dentegra.com, or by mailing payment to the address below:

Dentegra Insurance Company

[P.O. Box 660138

Dallas, TX 75266-0138]

## Rate Guarantee

Your initial Premium rate is guaranteed for the first 12 months of your Policy, based upon the new enrollee rates in force at the time of your enrollment. The rate guarantee can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change.

No change in Premiums shall become effective within a Policy Term, unless Dentegra's liability is changed by law or regulation. Such a change may include a state and/or federal mandated change or a new or increased tax, assessment or fee imposed on the amounts payable to, or by, Dentegra under this Policy or any immediately preceding Policy between Company and you. Company would provide written notice to you, and this Policy shall thereby be modified on the date set forth in the notice.

## Changing Payment Options

Payment options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on your new billing period. You can change your payment option [by[D8] visiting our website at [dentegra.com] or] by contacting our Customer Service department toll-free at [877-280-4204].

## Grace Period on Late Payments

If your Premium payment is not received by the first of the month, a grace period of 90 days will be granted. During the first 31 days of the grace period, the Policy shall continue in force. If premiums are not received by the 31st day of the grace period, claims will be placed on hold until the 90th day of the grace period. If premiums are not received by the 90th day of the grace period, your policy will be terminated as of the 31st day of the grace period.

# GRIEVANCES AND APPEALS

If you have questions about any services received, we recommend that you first discuss the matter with your Provider. However, if you continue to have concerns, please call our Customer Service Center. You can also e-mail questions by accessing the "Contact Us" section of our website at [dentegra.com].

Grievances regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Dentegra, or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at [877-280-4204].

When you write, please include the name of the Pediatric Enrollee, the ID number, and your telephone number on all correspondence. You should also include a copy of the Claim Form, claim statement, or other relevant information. Your claim statement will have an explanation of the claim review and any grievance process and time limits applicable to such process.

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, based upon lack of medical necessity. Any such denial will be based upon a determination by a Provider who holds a non-restricted license in the same or an appropriate specialty that typically manages the dental condition, procedure, or treatment under review. You and your Provider have at least 180 days after receiving a notice of denial to request a review by writing to Dentegra giving reasons why you believe the denial was wrong. You may also ask Dentegra to examine any additional information you include that may support your grievance.

Send your grievance to us at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

We will send you a written acknowledgment within 5 days upon receipt of your grievance. We will make a full and fair review within 30 days after we receive the grievance. We may ask for more documents if needed. We will send you a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Policy, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

## Appeals

If you believe you need further review of your claim and/or your grievance, you may contact your state insurance regulatory agency.

# PROVISIONS REQUIRED BY LAW

## Entire Contract; Changes

This Policy, including the endorsements and the attached papers, constitutes the entire contract of insurance. No change to this Policy shall be valid until approved by our executive officer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

## Incontestability

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by you in the application for this Policy will be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 3-year period.

No claim for loss incurred or disability commencing after three (3) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss has existed prior to the Effective Date of this Policy.

## Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us when and as often as it may reasonably require during the pendency of a claim, in or near your community or residence. We will in every case hold such information and records confidential.

## Written Notice of Claim / Proof of Loss

We must be given written proof of loss within 15 months after the date of the loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required, provided that the proof is filed as soon as reasonably possible. A notice of claim submitted by you, on your behalf, or on behalf of your beneficiary to us or to our authorized agent, with information sufficient to identify you will be considered notice of claim.

All written proof of loss must be given to us within 12 months of the termination of this Policy.

Send your Notice of Claim/Proof of Loss to us at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

## Claim Form

We will, within 20 days after receiving a notice of a claim, provide you or your Provider with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If we do not send you or your Provider a Claim Form within 15 days after you or your Provider gave us notice regarding a claim, the requirements for proof of loss outlined in the section "Written Notice of Claim/Proof of Loss" above will be deemed to have been complied with as long as you give us written proof that explains the type and the extent of the loss that you are making a claim for within the time established for filing proofs of loss. You may download a Claim Form from our website.

## Time of Payment

Claims payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be processed immediately after written proof of loss is received in the form required by the terms of this Policy. We will notify you and your Provider of any additional information needed to process the claim.

## To Whom Benefits Are Paid

It is not required that the service be provided by a specific dentist. Payment for services provided by a Dentegra Provider will be made directly to the dentist. Any other payments provided by the Policy will be made to you, unless you request when filing a proof of claim that the payment be made directly to the dentist providing the services. All benefits not paid to the Provider will be payable to you or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

## Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by you will be deemed

representations and not warranties. No such statement will be used in defense to a claim under this Policy, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the Policy at the same Premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the Premium to reflect your actual circumstances at time of application or to terminate your policy.

## Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Policy, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by this Policy.

## Conformity with State Laws

All legal questions about this Policy will be governed by the state of Tennessee where this Policy was entered into and is to be performed. Any part of this Policy which conflicts with the laws of Tennessee or federal law is hereby amended to conform to the minimum requirements of such laws.

## Third Party Administrator (“TPA”)

Dentegra may use the services of a TPA, duly registered under applicable state law, to provide services under this Contract. Any TPA providing such services or receiving such information will enter into a separate Business Associate Agreement with Dentegra providing that the TPA shall meet HIPAA and HITECH requirements of the preservation of protected health information of Pediatric Enrollees.

# NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice is required by law to tell you how Dentegra protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Dentegra receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Dentegra program, and we will notify you of how you can receive a copy of this notice every three years.

## Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Dentegra in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate. These affiliates have also implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

**Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations**

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.
  *For example, Dentegra may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment.
  *For example, Dentegra may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations.
  *For example, Dentegra may use and disclose your PHI to review the quality of care provided by our network of providers.*

**Disclosures Without an Authorization**

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Dentegra may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

**Disclosures Dentegra Makes With Your Authorization**

Dentegra will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Dentegra or by a person requesting your PHI from Dentegra.

**Your Rights Regarding PHI**

**You have the right to request an inspection of and obtain a copy of your PHI.** You may access your PHI by contacting the appropriate Dentegra office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Dentegra may charge a reasonable fee for providing you copies of your PHI. Dentegra will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Dentegra to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Dentegra does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

**You have the right to request a restriction of your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

**You have the right to correct or update your PHI.** This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

**You have the right to request or receive confidential communications from us by alternative means or at a different address.** We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

**You have the right to get this notice by email.** You have the right to get a copy of this notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice.

**Complaints**

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Dentegra has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

**Contact**

You may contact the privacy office at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Dentegra Insurance Company
c/o Office of Compliance
[P.O. Box 1850
Alpharetta, GA 30023-1850]

Phone: [877-280-4204]

**This notice is effective on and after August 1, 2012.**

# EMPLOYEE NOTICE

# NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

## COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
(2) the insurer was not authorized to do business in this state;
(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) any policy of reinsurance (unless an assumption certificate was issued);
(3) interest rate yields that exceed an average rate;
(4) dividends;
(5) credits given in connection with the administration of a policy by a group contract holder;
(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
(7) unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

## LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**Tennessee Life and Health Insurance Guaranty Association 150 3rd Avenue South, Suite 1600 Nashville, TN 37201**

**Tennessee Department of Commerce and Insurance 500 James Robertson Parkway Nashville,Tennessee 37243**

# Attachment A
# Benefit Summary
# Dentegra Dental PPO
# Children's Plan 85

**Responsible Party: [Name]**

**Effective Date: [XXXXX]**

**Policy ID Number: [XXXX]**

**Premium:** [Per[D1] Pediatric Enrollee:] [$ X[D2]XXX]

***Premiums are to be remitted [monthly][D3] to:***
**Dentegra Insurance Company**
[Street[D4] PO Box 660138
Dallas, TX 75266-0138]

You have a Calendar Year plan and Deductibles and Out-of-Pocket maximums will be based upon a Calendar Year. If you enroll mid-year due to a Qualifying Status Change, your Policy Year will be shorter than 12 months and will begin again on January 1.

**Annual Deductible**
$25 per Pediatric Enrollee each Calendar Year
The annual Deductible will be waived for Diagnostic and Preventive Services.

**Annual Out-of-Pocket Maximum for Dentegra PPO℠ Providers***
Individual $700 each Calendar Year
Multiple Child $1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount that a Pediatric Enrollee must satisfy for covered services under the Policy during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If a Responsible Party covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from Dentegra PPO Providers.

| **Policy Benefit Levels** | | |
|---|---|---|
| **Dental Service Category** | **Dentegra PPO Providers†** | **Non-Dentegra Providers†** |
| Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for the following services: | | |
| **Diagnostic and Preventive Services** | 100% | 100% |
| **Basic Services** | 80% | 80% |
| **Major Services** | 50% | 50% |
| **Medically Necessary Orthodontic Services (requires Prior Authorization)** | 50% | 50% |

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

# Attachment A
# Benefit Summary
# Dentegra Dental PPO
# Children's Plan 70

**Responsible Party: [Name]**

**Effective Date: [XXXXX]**

**Policy ID Number: [XXXX]**

**Premium:** [Per[D1] Pediatric Enrollee:] [$ X[D2]XXX]

***Premiums are to be remitted [monthly][D3] to:***
**Dentegra Insurance Company**
[Street[D4] PO Box 660138
Dallas, TX 75266-0138]

You have a Calendar Year plan and Deductibles and Out-of-Pocket maximums will be based upon a Calendar Year. If you enroll mid-year due to a Qualifying Status Change, your Policy Year will be shorter than 12 months and will begin again on January 1.

**Annual Deductible**
$45 per Pediatric Enrollee each Calendar Year

**Annual Out-of-Pocket Maximum for Dentegra PPO℠ Providers***
Individual $700 each Calendar Year
Multiple Child $1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount that a Pediatric Enrollee must satisfy for covered services under the Policy during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If a Responsible Party covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from Dentegra PPO Providers.

| **Policy Benefit Levels** | | |
|---|---|---|
| **Dental Service Category** | **Dentegra PPO Providers†** | **Non-Dentegra Providers†** |
| Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for the following services: | | |
| **Diagnostic and Preventive Services** | 100% | 100% |
| **Basic Services** | 50% | 50% |
| **Major Services** | 50% | 50% |
| **Medically Necessary Orthodontic Services (requires Prior Authorization)** | 50% | 50% |

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

# Attachment B
# Services, Limitations and Exclusions
# Dentegra Dental PPO
# Children's Plan [85/70][D1]

***Description of Dental Services***

Dentegra will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for the services shown on Attachment B-1 when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthodontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a Prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

***Limitations***

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

(3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(4) Dentegra will pay for oral examinations (except exams for observation) no more than twice in a Calendar Year. Only one (1) comprehensive evaluation is allowed in a Calendar Year and counts toward the oral examination frequency in the year provided. One (1) limited oral evaluation, problem-focused no more than once in a Calendar Year.

(5) X-ray limitations:
- a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
- b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
- c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
- d) A complete intraoral series and panoramic film are each limited to once every 60 months.
- e) Bitewing x-rays are limited to two (2) times in a Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(6) Dentegra will pay for routine cleanings and topical application of fluoride solutions no more than twice in a Calendar Year, and periodontal cleanings in the presence of inflamed gums up to four (4) times in a Calendar Year. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings not to exceed four (4) procedures or any combination thereof in a Calendar Year. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic

and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

(7) Space maintainer limitations:
   a) Space maintainers are limited to the initial appliance.
   b) Recementation of space maintainer is limited to once per lifetime.
   c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(8) Sealants are limited as follows:
   a) to permanent molars through age 18 if they are without caries (decay) or restorations on the occlusal surface.
   b) do not include repair or replacement of a Sealant on any tooth within 36 months of its application.

(9) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.

(10) Dentegra will not cover to replace an amalgam or resin-based composite within 24 months of treatment if the service is provided by the same Provider/Provider office. Pefabricated stainless steel crowns are limited to once per Enrollee per tooth per lifetime. Replacement restorations within 24 months are included in the fee for the original restoration.

(11) Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 15.

(12) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only. It is a benefit for primary incisor teeth up to age six (6) and for primary molars and cuspids to age 11.

(13) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(14) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

(15) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(16) Retrograde fillings per root are limited to once in any 24-month period.

(17) Pin retention is covered not more than once in any 24-month period.

(18) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(19) Periodontal limitations:
   a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.
   b) Periodontal surgery in the same quadrant is limited to once in every 24-month period and includes any surgical re-entry or scaling and root planing.
   c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
   d) If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
   e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
   f) One crown lengthening per tooth per lifetime.

(20) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(21) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Dentegra determines the existing Crown

or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(22) When an alternate Benefit of an amalgam is allowed for inlays/ onlays, they are limited to Enrollees age 12 and older and are covered not more than once in any 60 month period.

(23) Core buildup, including any pins, are covered not more than once in any 60 month period.

(24) Post and core services are covered not more than once in any 60 month year period.

(25) Crown repairs are covered not more than once in any 60 month period.

(26) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(27) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(28) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Dentegra program will be replaced only after 60 months have passed, except when Dentegra determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Removable cast base partial dentures are limited to Enrollees age 12 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if Dentegra determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.

(29) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(30) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a (6) month period by the same Provider/Provider office.

(31) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Dentegra plan or Enrollee's prior plan, if applicable

(32) Dentegra limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
   a) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
   b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments and relining are limited to one (1) per arch in a 36-month period.
   c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
   d) Recementation of fixed partial dentures is limited to once in a lifetime.

(33) Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period.

(34) Athletic mouth guards are limited to one (1) per 12 consecutive month period.

(35) Internal bleaching of discolored teeth shall not be provided for any tooth more than once each 36 months while the patient is an Enrollee under any Dentegra plan.

***Exclusions***

**Dentegra does not pay Benefits for:**

(1) services not included on Attachment B-1 Schedule of Covered Services except medically necessary Orthodontics provided a Prior Authorization is obtained.

(2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) cosmetic surgery or procedures for purely cosmetic reasons.

(4) maxillofacial prosthetics.

(5) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under).

(6) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

(7) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.

(8) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(9) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(10) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures if such procedures included in Attachment B-1.

(11) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(12) laboratory processed crowns for Enrollees under age 12.

(13) fixed bridges and removable partials for Enrollees under age 16.

(14) indirectly fabricated resin-based Inlays/Onlays.

(15) overdentures.

(16) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(17) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(18) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(19) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(20) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(21) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.

(22) Deductibles and/or any service not covered under the dental plan.

(23) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(24) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Policy or was covered under any dental care plan with Dentegra or the Enrollee's prior dental plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(25) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(26) endodontic endosseous implant.

# Attachment B-1
# Schedule of Covered Services and Limitations

***Please note the following:***

• Dentegra will pay Benefits for dental services described in this attachment when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

• Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

• The codes and nomenclature in this Schedule are copyright of the American Dental Association. This table represents codes and nomenclature excerpted from the version of Current Dental Terminology (CDT)© in effect at the date of this printing. Dentegra's administration of benefits, limitations and exclusions under this plan at all times will be based on the current version of CDT whether or not a revised table is provided.

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| D&P | D0120 | Periodic oral evaluation - established patient | 2 in a calendar year |
| D&P | D0140 | Limited oral evaluation - problem focused | 1 in a calendar year |
| D&P | D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | |
| D&P | D0150 | Comprehensive oral evaluation - new or established patient | 1 in a calendar year |
| D&P | D0160 | Detailed and extensive oral evaluation - problem focused, by report | problem focused, by report |
| D&P | D0180 | Comprehensive periodontal evaluation - new or established patient | 2 in a calendar year |
| D&P | D0210 | Intraoral - complete series of radiographic images | Limited to 1 every 5 years |
| D&P | D0220 | Intraoral - periapical first radiographic image | |
| D&P | D0230 | Intraoral - periapical each additional radiographic image | |
| D&P | D0240 | Intraoral - occlusal radiographic image | |
| D&P | D0250 | Extraoral - first radiographic image | |
| D&P | D0260 | Extraoral - each additional radiographic image | |
| D&P | D0270 | Bitewing - single radiographic image | |
| D&P | D0272 | Bitewings - two radiographic images | 2 in a calendar year |
| D&P | D0273 | Bitewings - three radiographic images | 2 in a calendar year |
| D&P | D0274 | Bitewings - four radiographic images | 2 in a calendar year |
| D&P | D0277 | Vertical bitewings - 7 to 8 radiographic images | |
| D&P | D0330 | Panoramic radiographic image | |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| D&P | D0425 | Caries susceptibility tests | |
| D&P | D1110 | Prophylaxis - adult | 2 in a calendar year |
| D&P | D1120 | Prophylaxis - child | 2 in a calendar year |
| D&P | D1206 | Topical application of fluoride varnish | |
| D&P | D1208 | Topical application of fluoride | 2 in a calendar year |
| D&P | D1351 | Sealant - per tooth | 1 per tooth every 36 months |
| D&P | D1352 | Preventive resin restoration in a moderate to high caries risk patient - permanent tooth | |
| D&P | D1510 | Space maintainer - fixed - unilateral | |
| D&P | D1515 | Space maintainer - fixed - bilateral | |
| D&P | D1520 | Space maintainer - removable - unilateral | |
| D&P | D1525 | Space maintainer - removable - bilateral | |
| D&P | D1550 | Re-cementation of space maintainer | |
| Basic | D2140 | Amalgam - one surface, primary or permanent | 1 every 24 month period |
| Basic | D2150 | Amalgam - two surfaces, primary or permanent | 1 every 24 month period |
| Basic | D2160 | Amalgam - three surfaces, primary or permanent | 1 every 24 month period |
| Basic | D2161 | Amalgam - four or more surfaces, primary or permanent | 1 every 24 month period |
| Basic | D2330 | Resin-based composite - one surface, anterior | 1 every 24 month period |
| Basic | D2331 | Resin-based composite - two surfaces, anterior | 1 every 24 month period |
| Basic | D2332 | Resin-based composite - three surfaces, anterior | 1 every 24 month period |
| Basic | D2335 | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | 1 every 24 month period |
| Basic | D2391 | Resin-based composite - one surface, posterior | 1 every 24 month period |
| Basic | D2392 | Resin-based composite - two surfaces, posterior | 1 every 24 month period |
| Basic | D2393 | Resin-based composite - three surfaces, posterior | 1 every 24 month period |
| Basic | D2394 | Resin-based composite - four or more surfaces, posterior | 1 every 24 month period |
| Major | D2510 | Inlay - metallic - one surface | |
| Major | D2520 | Inlay - metallic - two surfaces | |
| Major | D2530 | Inlay - metallic - three or more surfaces | |
| Major | D2542 | Onlay - metallic-two surfaces | Limited to 1 every 5 years |
| Major | D2543 | Onlay - metallic-three surfaces | Limited to 1 every 5 years |
| Major | D2544 | Onlay - metallic-four or more surfaces | Limited to 1 every 5 years |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D2740 | Crown - porcelain/ceramic substrate | |
| Major | D2750 | Crown - porcelain fused to high noble metal | Limited to 1 every 5 years |
| Major | D2751 | Crown - porcelain fused to predominantly base metal | Limited to 1 every 5 years |
| Major | D2752 | Crown - porcelain fused to noble metal | Limited to 1 every 5 years |
| Major | D2780 | Crown - 3/4 cast high noble metal | Limited to 1 every 5 years |
| Major | D2781 | Crown - 3/4 cast predominantly base metal | Limited to 1 every 5 years |
| Major | D2782 | Crown - 3/4 cast noble metal | Limited to 1 every 5 years |
| Major | D2783 | Crown - 3/4 porcelain/ceramic | Limited to 1 every 5 years |
| Major | D2790 | Crown - full cast high noble metal | Limited to 1 every 5 years |
| Major | D2791 | Crown - full cast predominantly base metal | Limited to 1 every 5 years |
| Major | D2792 | Crown - full cast noble metal | Limited to 1 every 5 years |
| Major | D2794 | Crown - titanium | Limited to 1 every 5 years |
| Major | D2910 | Recement inlay, onlay, or partial coverage restoration | Once per 6-month period |
| Major | D2920 | Recement crown | Once per 6-month period |
| Basic | D2930 | Prefabricated stainless steel crown - primary tooth | |
| Basic | D2931 | Prefabricated stainless steel crown - permanent tooth | |
| Major | D2950 | Core buildup, including any pins | Limited to 1 every 5 years |
| Major | D2951 | Pin retention - per tooth, in addition to restoration | Limited to 1 every 24 months |
| Major | D2954 | Prefabricated post and core in addition to crown | Limited to 1 every 5 years |
| Major | D2980 | Crown repair necessitated by restorative material failure | |
| Major | D2981 | Inlay repair necessitated by restorative material failure | |
| Major | D2982 | Onlay repair necessitated by restorative material failure | |
| Major | D2983 | Veneer repair necessitated by restorative material failure | |
| Basic | D2990 | Resin infiltration of incipient smooth surface lesions | |
| Major | D3110 | Pulp cap - direct (excluding final restoration) | |
| Major | D3120 | Pulp cap - indirect (excluding final restoration) | |
| Major | D3220 | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | |
| Major | D3221 | Pulpal debridement, primary and permanent teeth | |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D3222 | Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | |
| Major | D3230 | Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | |
| Major | D3240 | Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | |
| Major | D3310 | Endodontic therapy, anterior tooth (excluding final restoration) | |
| Major | D3320 | Endodontic therapy, bicuspid tooth (excluding final restoration) | |
| Major | D3330 | Endodontic therapy, molar (excluding final restoration) | |
| Major | D3346 | Retreatment of previous root canal therapy - anterior | |
| Major | D3347 | Retreatment of previous root canal therapy - bicuspid | |
| Major | D3348 | Retreatment of previous root canal therapy - molar | |
| Major | D3351 | Apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) | |
| Major | D3352 | Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) | |
| Major | D3353 | Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | |
| Major | D3354 | Pulpal regeneration - (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration | |
| Major | D3410 | Apicoectomy/periradicular surgery - anterior | |
| Major | D3421 | Apicoectomy/periradicular surgery - bicuspid (first root) | |
| Major | D3425 | Apicoectomy/periradicular surgery - molar (first root) | |
| Major | D3426 | Apicoectomy/periradicular surgery (each additional root) | |
| Major | D3430 | Retrograde filling - per root | |
| Major | D3450 | Root amputation - per root | |
| Major | D3920 | Hemisection (including any root removal), not including root canal therapy | |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | Limited to 1 every 24 months |
| Major | D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | Limited to 1 every 24 months |
| Major | D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | Limited to 1 every 24 months |
| Major | D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | Limited to 1 every 24 months |
| Major | D4241 | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | Limited to 1 every 24 months |
| Major | D4249 | Clinical crown lengthening - hard tissue | |
| Major | D4260 | Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | Limited to 1 every 24 months |
| Major | D4261 | Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | Limited to 1 every 24 months |
| Major | D4268 | Surgical revision procedure, per tooth | |
| Major | D4270 | Pedicle soft tissue graft procedure | |
| Major | D4273 | Subepithelial connective tissue graft procedures, per tooth | |
| Major | D4275 | Soft tissue allograft | |
| Major | D4276 | Combined connective tissue and double pedicle graft, per tooth | |
| Major | D4277 | Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft | |
| Major | D4278 | Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site | |
| Major | D4341 | Periodontal scaling and root planing - four or more teeth per quadrant | Limited to 1 every 24 months |
| Major | D4342 | Periodontal scaling and root planing - one to three teeth per quadrant | Limited to 1 every 24 months |
| Basic | D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis | Limited to 1 per lifetime |
| Major | D4381 | Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth | |
| Basic | D4910 | Periodontal maintenance | Up to 4 periodontal maintenance procedures and up to 2 routine cleanings not to exceed 4 |
| Major | D5110 | Complete denture - maxillary | Limited to 1 every 5 years |
| Major | D5120 | Complete denture - mandibular | Limited to 1 every 5 years |
| Major | D5130 | Immediate denture - maxillary | Limited to 1 every 5 years |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D5140 | Immediate denture - mandibular | Limited to 1 every 5 years |
| Major | D5211 | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) | Limited to 1 every 5 years |
| Major | D5212 | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | Limited to 1 every 5 years |
| Major | D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | Limited to 1 every 5 years |
| Major | D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | Limited to 1 every 5 years |
| Major | D5281 | Removable unilateral partial denture - one piece cast metal (including clasps and teeth) | Limited to 1 every 5 years |
| Major | D5410 | Adjust complete denture - maxillary | |
| Major | D5411 | Adjust complete denture - mandibular | |
| Major | D5421 | Adjust partial denture - maxillary | |
| Major | D5422 | Adjust partial denture - mandibular | |
| Major | D5510 | Repair broken complete denture base | |
| Major | D5520 | Replace missing or broken teeth - complete denture (each tooth) | |
| Major | D5610 | Repair resin denture base | |
| Major | D5620 | Repair cast framework | |
| Major | D5630 | Repair or replace broken clasp | |
| Major | D5640 | Replace broken teeth - per tooth | |
| Major | D5650 | Add tooth to existing partial denture | |
| Major | D5660 | Add clasp to existing partial denture | |
| Major | D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | |
| Major | D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | |
| Major | D5710 | Rebase complete maxillary denture | Limited to 1 in a 36-months |
| Major | D5711 | Rebase complete mandibular denture | Limited to 1 in a 36-months |
| Major | D5720 | Rebase maxillary partial denture | Limited to 1 in a 36-months |
| Major | D5721 | Rebase mandibular partial denture | Limited to 1 in a 36-months |
| Major | D5730 | Reline complete maxillary denture (chairside) | Limited to 1 in a 36-months |
| Major | D5731 | Reline complete mandibular denture (chairside) | Limited to 1 in a 36-months |
| Major | D5740 | Reline maxillary partial denture (chairside) | Limited to 1 in a 36-months |
| Major | D5741 | Reline mandibular partial denture (chairside) | Limited to 1 in a 36-months |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D5750 | Reline complete maxillary denture (laboratory) | Limited to 1 in a 36-months |
| Major | D5751 | Reline complete mandibular denture (laboratory) | Limited to 1 in a 36-months |
| Major | D5760 | Reline maxillary partial denture (laboratory) | Limited to 1 in a 36-months |
| Major | D5761 | Reline mandibular partial denture (laboratory) | Limited to 1 in a 36-months |
| Major | D5850 | Tissue conditioning, maxillary | |
| Major | D5851 | Tissue conditioning, mandibular | |
| Major | D6010 | Surgical placement of implant body: endosteal implant | Limited to 1 every 5 years |
| Major | D6053 | Implant/abutment supported removable denture for completely edentulous arch | Limited to 1 every 5 years |
| Major | D6054 | Implant/abutment supported removable denture for partially edentulous arch | Limited to 1 every 5 years |
| Major | D6055 | Connecting bar - implant supported or abutment supported | Limited to 1 every 5 years |
| Major | D6056 | Prefabricated abutment - includes modification and placement | Limited to 1 every 5 years |
| Major | D6057 | Custom fabricated abutment - includes placement | Limited to 1 every 5 years |
| Major | D6058 | Abutment supported porcelain/ceramic crown | Limited to 1 every 5 years |
| Major | D6059 | Abutment supported porcelain fused to metal crown (high noble metal) | Limited to 1 every 5 years |
| Major | D6060 | Abutment supported porcelain fused to metal crown (predominantly base metal) | Limited to 1 every 5 years |
| Major | D6061 | Abutment supported porcelain fused to metal crown (noble metal) | Limited to 1 every 5 years |
| Major | D6062 | Abutment supported cast metal crown (high noble metal) | Limited to 1 every 5 years |
| Major | D6063 | Abutment supported cast metal crown (predominantly base metal) | Limited to 1 every 5 years |
| Major | D6064 | Abutment supported cast metal crown (noble metal) | Limited to 1 every 5 years |
| Major | D6065 | Implant supported porcelain/ceramic crown | Limited to 1 every 5 years |
| Major | D6066 | Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) | Limited to 1 every 5 years |
| Major | D6067 | Implant supported metal crown (titanium, titanium alloy, high noble metal) | Limited to 1 every 5 years |
| Major | D6068 | Abutment supported retainer for porcelain/ceramic FPD | Limited to 1 every 5 years |
| Major | D6069 | Abutment supported retainer for porcelain fused to metal FPD (high noble metal) | Limited to 1 every 5 years |
| Major | D6070 | Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) | Limited to 1 every 5 years |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D6071 | Abutment supported retainer for porcelain fused to metal FPD (noble metal) | Limited to 1 every 5 years |
| Major | D6072 | Abutment supported retainer for cast metal FPD (high noble metal) | Limited to 1 every 5 years |
| Major | D6073 | Abutment supported retainer for cast metal FPD (predominantly base metal) | Limited to 1 every 5 years |
| Major | D6074 | Abutment supported retainer for cast metal FPD (noble metal) | Limited to 1 every 5 years |
| Major | D6075 | Implant supported retainer for ceramic FPD | Limited to 1 every 5 years |
| Major | D6076 | Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) | Limited to 1 every 5 years |
| Major | D6077 | Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) | Limited to 1 every 5 years |
| Major | D6078 | Implant/abutment supported fixed denture for completely edentulous arch | Limited to 1 every 5 years |
| Major | D6079 | Implant/abutment supported fixed denture for partially edentulous arch | Limited to 1 every 5 years |
| Major | D6080 | Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis | Limited to 1 every 5 years |
| Major | D6090 | Repair implant supported prosthesis, by report | Limited to 1 every 5 years |
| Major | D6091 | Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment | Limited to 1 every 5 years |
| Major | D6094 | Abutment supported crown - (titanium) | Limited to 1 every 5 years |
| Major | D6095 | Repair implant abutment, by report | Limited to 1 every 5 years |
| Major | D6100 | Implant removal, by report | Limited to 1 every 5 years |
| Major | D6194 | Abutment supported retainer crown for FPD - (titanium) | Limited to 1 every 5 years |
| Major | D6210 | Pontic - cast high noble metal | Limited to 1 every 5 years |
| Major | D6211 | Pontic - cast predominantly base metal | Limited to 1 every 5 years |
| Major | D6212 | Pontic - cast noble metal | Limited to 1 every 5 years |
| Major | D6214 | Pontic - titanium | Limited to 1 every 5 years |
| Major | D6240 | Pontic - porcelain fused to high noble metal | Limited to 1 every 5 years |
| Major | D6241 | Pontic - porcelain fused to predominantly base metal | Limited to 1 every 5 years |
| Major | D6242 | Pontic - porcelain fused to noble metal | Limited to 1 every 5 years |
| Major | D6245 | Pontic - porcelain/ceramic | Limited to 1 every 5 years |
| Major | D6545 | Retainer - cast metal for resin bonded fixed prosthesis | Limited to 1 every 5 years |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D6548 | Retainer - porcelain/ceramic for resin bonded fixed prosthesis | Limited to 1 every 5 years |
| Major | D6601 | Inlay - porcelain/ceramic, three or more surfaces | Limited to 1 every 5 years |
| Major | D6604 | Inlay - cast predominantly base metal, two surfaces | Limited to 1 every 5 years |
| Major | D6605 | Inlay - cast predominantly base metal, three or more surfaces | Limited to 1 every 5 years |
| Major | D6613 | Onlay - cast predominantly base metal, three or more surfaces | Limited to 1 every 5 years |
| Major | D6740 | Crown - porcelain/ceramic | Limited to 1 every 5 years |
| Major | D6750 | Crown - porcelain fused to high noble metal | Limited to 1 every 5 years |
| Major | D6751 | Crown - porcelain fused to predominantly base metal | Limited to 1 every 5 years |
| Major | D6752 | Crown - porcelain fused to noble metal | Limited to 1 every 5 years |
| Major | D6780 | Crown - 3/4 cast high noble metal | Limited to 1 every 5 years |
| Major | D6781 | Crown - 3/4 cast predominantly based metal | Limited to 1 every 5 years |
| Major | D6782 | Crown - 3/4 cast noble metal | Limited to 1 every 5 years |
| Major | D6783 | Crown - 3/4 porcelain/ceramic | Limited to 1 every 5 years |
| Major | D6790 | Crown - full cast high noble metal | Limited to 1 every 5 years |
| Major | D6791 | Crown - full cast predominantly base metal | Limited to 1 every 5 years |
| Major | D6792 | Crown - full cast noble metal | Limited to 1 every 5 years |
| Major | D6794 | Crown - titanium | Limited to 1 every 5 years |
| Major | D6930 | Recement fixed partial denture | |
| Major | D6980 | Fixed partial denture repair necessitated by restorative material failure | |
| Major | D7111 | Extraction, coronal remnants - deciduous tooth | |
| Major | D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | |
| Major | D7210 | Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | |
| Major | D7220 | Removal of impacted tooth - soft tissue | |
| Major | D7230 | Removal of impacted tooth - partially bony | |
| Major | D7240 | Removal of impacted tooth - completely bony | |
| Major | D7241 | Removal of impacted tooth - completely bony, with unusual surgical complications | |
| Major | D7250 | Surgical removal of residual tooth roots (cutting procedure) | |
| Major | D7251 | Coronectomy - intentional partial tooth removal | |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | |
| Major | D7280 | Surgical access of an unerupted tooth | |
| Major | D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | |
| Major | D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | |
| Major | D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | |
| Major | D7321 | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | |
| Major | D7471 | Removal of lateral exostosis (maxilla or mandible) | |
| Major | D7510 | Incision and drainage of abscess - intraoral soft tissue | |
| Major | D7910 | Suture of recent small wounds up to 5 cm | |
| Major | D7921 | Collection and application of autologous blood concentrate product | |
| Major | D7971 | Excision of pericoronal gingiva | |
| Major | D7999 | Unspecified oral surgery procedure, by report | |
| Basic | D9110 | Palliative (emergency) treatment of dental pain - minor procedure | |
| Basic | D9220 | Deep sedation/general anesthesia - first 30 minutes | |
| Basic | D9221 | Deep sedation/general anesthesia - each additional 15 minutes | |
| Basic | D9241 | Intravenous conscious sedation/analgesia - first 30 minutes | |
| Basic | D9242 | Intravenous conscious sedation/analgesia - each additional 15 minutes | |
| D&P | D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | 1 per lifetime |
| Basic | D9440 | Office visit - after regularly scheduled hours | |
| Basic | D9610 | Therapeutic parenteral drug, single administration | |
| Basic | D9612 | Therapeutic parenteral drugs, two or more administrations, different medications | |
| Basic | D9930 | Treatment of complications (post-surgical) - unusual circumstances, by report | |
| Major | D9940 | Occlusal guard, by report | 1 in 12 months for patients 13 and older |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D9941 | Fabrication of athletic mouthguard | |
| Major | D9974 | Internal bleaching - per tooth | |
| Major | D9999 | Unspecified adjunctive procedure, by report | |

[State logo[D1]]


# Dentegra® Dental PPO

## Children's [Plan 70/85[D2]] + Adult [Basic/Preferred[D3]]

Combined Policy and Disclosure Form

Provided by:

Dentegra Insurance Company

variable text - highlight & delete if not needed
variable text - highlight & delete if not needed

**This Policy is conditionally renewable and may be terminated if all policies in this state are terminated.**

[dentegra[D4].com]

[State website and phone number[D5]]

# Policy

Your dental plan is underwritten by Dentegra® Insurance Company("Dentegra") and administered by Delta Dental Insurance Company. Dentegra will pay Benefits for covered dental services as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first installment of Premium. It takes effect on the Effective Date shown on Attachments A and C ("Attachment A" and "Attachment C") attached to this Policy. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where you live.

**READ YOUR POLICY AND ATTACHMENTS CAREFULLY**

**Ten 10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY**

Please read this Policy. If this Policy was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements or if you are not satisfied for any reason, you may return the Policy within ten (10) days after its delivery. Mail or deliver it to Dentegra's home office or to the agent through whom you purchased it. Any Premium paid will be refunded. This Policy will then be void from its start.

This Policy is signed for Dentegra, as of its Effective Date by:

Anthony S. Barth, Vice Chairman

# Table of Contents

# INTRODUCTION

We are pleased to welcome you to this individual Dentegra PPO dental plan. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

**Essential Health Benefit Plan –** The Essential Health Benefit Plan ("Pediatric Benefits") provides coverage to Eligible Pediatric Enrollees who are the Primary Enrollee's dependent children. Such children are eligible for Benefits under this Policy from birth to age 26. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulation.

**Supplemental Adult Benefit Plan –** The Adult Benefit Plan provides coverage for the Primary Enrollee and Eligible Dependents who are the Primary Enrollee's Spouse and children to age 26. Dependent children of the Primary Enrollee include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulation.

**NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.**

## Using This Policy

This Policy discloses the terms and conditions of the coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that "you" and "your" mean the Enrollees who are covered under this Policy. "We", "us" and "our" always refer to Dentegra.

## Contact Us

If you have any questions about your coverage that are not answered here, please visit our website at [dentegra[D6].com] or call our Customer Service Center. A Customer Service representative can answer questions you may have about obtaining dental care, help you locate a Dentegra Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at [877-280-4204] during regular business hours to obtain information about Enrollee Benefits, claim status or to speak to a Customer Service representative for assistance. If you prefer to write to us with your question(s) please mail your inquiry to the following address:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

## Identification Number

Please provide the Enrollee's ID number to your Provider whenever you receive dental services. The Enrollee ID number should be included on all claims submitted for payment. Identification cards are not required, but if you wish to have one you may obtain one by visiting our website at [dentegra.com].

# DEFINITIONS

The following are definitions of words that have special or technical meanings under this Policy.

**Accepted Fee:** the amount the attending Provider agrees to accept as payment in full for services rendered.

**Benefits (In-Network or Out-of-Network)**: the amounts that Dentegra will pay for dental services under this Policy. In-Network Benefits are those covered by this Policy and performed by a Dentegra Provider. Out-of-Network Benefits are those covered by this Policy but performed by a Non-Dentegra Provider.

**Benefit Year/Calendar Year:** the 12 months of the year from January 1 through December 31.

**Claim Form:** the standard form used to file a claim or request a Pre-Treatment Estimate.

**Dentegra PPO$^{SM}$ Provider (Dentegra Provider):** a Provider who contracts with Dentegra and agrees to accept the Dentegra Provider's Contracted Fees as payment in full for services provided under this PPO plan.

**Dentegra PPO Provider's Contracted Fee (Dentegra Provider's Contracted Fee):** the fee for each Single Procedure that Dentegra Providers have contractually agreed to accept as payment in full for treating Enrollees.

**Effective Date**: The original date the plan starts. This date is given in Attachments A and C.

**Enrollee**: an Eligible Enrollee ("Primary Enrollee" or "Qualified Individual"), Eligible Dependent ("Dependent Enrollee") or Eligible Pediatric Enrollee ("Pediatric Enrollee") enrolled to receive Benefits.

**Exchange**: The Tennessee Federally Facilitated Marketplace Exchange.

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**Maximum Contract Allowance:** the reimbursement under the Enrollee's benefit plan against which Dentegra calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a Dentegra Provider is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee; or
- by a Non-Dentegra Provider is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee for a PPO Provider in the same geographic area.

**Non-Dentegra Provider:** a Provider who is not a Dentegra Provider and who is not contractually bound to abide by Dentegra's administrative guidelines.

**Open Enrollment Period:** the period of the year that the Exchange has established when the Eligible Enrollee may change coverage selections for the next Policy Year.

**Policy:** means this agreement between Dentegra and Primary Enrollee including the application if supplied by the Tennessee Federally Facilitated Marketplace Exchange, any attached amendments and appendices. This Policy constitutes the entire agreement between the parties.

**Policy Benefit Level:** the percentage of Maximum Contract Allowance that Dentegra will pay.

**Policy Term:** the period during which this Policy is in effect.

**Policy Year:** the 12 months starting on January 1st and each subsequent 12 month period thereafter coinciding with the Benefit Year. Policy Year can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change.

**Premium:** the amount payable as provided in Attachments A and C.

**Pre-Treatment Estimate:** an estimation of the allowable Benefits under this Policy for the services proposed, assuming the person is an eligible Enrollee.

**Procedure Code:** the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

**Program Allowance:** the amount determined by a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area.

**Provider:** a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

**Qualified Individual:** an individual determined by the Tennessee Federally Facilitated Marketplace Exchangeto be eligible to enroll through the Exchange.

**Qualifying Status Change:** a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- dependent child ceases to satisfy eligibility requirements;
- a court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by the Exchange.

**Single Procedure**: a dental procedure that is assigned a separate Procedure Code.

**Spouse**: a person related to or a partner of the Eligible Enrollee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where this Policy is issued and delivered; or
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Eligible Enrollee resides.

**Submitted Fee:** the amount that the Provider bills and enters on a claim for a specific procedure.

# OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how this dental plan works and how to make it work best for you.

## Benefits, Limitations and Exclusions

We will pay Benefits for the types of dental services as described in Attachment B Services, Limitations and Exclusions For Pediatric Benefits ("Attachment B") and Attachment B-1 Schedule of Covered Services and Limitations for Pediatric Benefits ("Attachment B-1");"; Attachment C Deductibles, Maximums and Policy Benefit Levels for Adult Benefits ("Attachment C"); Attachment D Services, Limitations and Exclusions for Adult Benefits ("Attachment D").

We will pay Benefits only for covered services. This Policy covers several categories of Benefits when a Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims shall be processed in accordance with our standard processing policies. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable

under this Policy. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

## Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown in the Attachments A and C, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled "Selecting Your Provider"). Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select Dentegra Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the section titled "Selecting Your Provider" for more information.

## Deductible

A deductible ("Deductible") is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts, if any, are listed in Attachments A and C. Deductibles apply to all covered dental services unless otherwise noted. Only the Provider's fees paid for covered Benefits will count toward the Deductible.

## Maximum Amount

A maximum amount ("Maximum Amount" or "Maximum") is the maximum dollar amount we will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. We will pay the Maximum Amount(s), if applicable, shown in Attachments A and C for Benefits under the Policy.

## Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under this Policy for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of this Policy when the treatment is actually performed. Pre-Treatment

Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

1) the date this Policy terminates;
2) the date the Enrollee's coverage ends; or
3) the date the Provider's agreement with Dentegra ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are covered and meet all the requirements of the plan at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

## GRIEVANCES AND APPEALS

If you have questions about any services received, we recommend that you first discuss the matter with your Provider. However, if you continue to have concerns, please call our Customer Service Center. You can also e-mail questions by accessing the "Contact Us" section of our website at [dentegra.com].

Grievancesregarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Dentegra, or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at [877-280-4204].

When you write, please include the name of the Enrollee, the ID number, and your telephone number on all correspondence. You should also include a copy of the Claim Form, claim statement, or other relevant information. Your claim statement will have an explanation of the claim review and any grievance process and time limits applicable to such process.

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, based upon lack of medical necessity. Any such denial will be based upon a determination by a Provider who holds a non-restricted license in the same or an appropriate specialty that typically manages the dental condition, procedure, or treatment under review. You and your Provider have at least 180 days after receiving a notice of denial to request a review by writing to Dentegra giving reasons why you believe the denial was wrong. You may also ask Dentegra to examine any additional information you include that may support your grievance.

Send your grievance to us at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

We will send you a written acknowledgment within 5 days upon receipt of your grievance. We will make a full and fair review within 30 days after we receive the grievance. We may ask for more documents if needed. We will send you a decision within 30 days. The review will take into account all comments, documents, records or

other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Policy, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

### Appeals

If you believe you need further review of your claim and/or your grievance, you may contact your state insurance regulatory agency.

## PROVISIONS REQUIRED BY LAW

### Entire Contract; Changes

This Policy, including the endorsements and the attached papers, constitutes the entire contract of insurance. No change to this Policy shall be valid until approved by our executive officer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

### Incontestability

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by you in the application for this Policy will be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 3-year period.

No claim for loss incurred or disability commencing after three (3) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss has existed prior to the Effective Date of this Policy.

### Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us when and as often as it may reasonably require during the pendency of a claim, in or near your community or residence. We will in every case hold such information and records confidential.

### Written Notice of Claim / Proof of Loss

We must be given written proof of loss within 15 months after the date of the loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required,

provided that the proof is filed as soon as reasonably possible. A notice of claim submitted by you, on your behalf, or on behalf of your beneficiary to us or to our authorized agent, with information sufficient to identify you will be considered notice of claim.

All written proof of loss must be given to us within 12 months of the termination of this Policy. Send your Notice of Claim/Proof of Loss to us at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30009]

## Claim Form

We will, within 20 days after receiving a notice of a claim, provide you or your Provider with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If we do not send you or your Provider a Claim Form within 15 days after you or your Provider gave us notice regarding a claim, the requirements for proof of loss outlined in the section "Written Notice of Claim/Proof of Loss" above will be deemed to have been complied with as long as you give us written proof that explains the type and the extent of the loss that you are making a claim for within the time established for filing proofs of loss. You may download a Claim Form from our website.

## Time of Payment

Claims payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be processed immediately after written proof of loss is received in the form required by the terms of this Policy. We will notify you and your Provider of any additional information needed to process the claim.

## To Whom Benefits Are Paid

It is not required that your services be provided by a specific dentist. Payment for services provided by a Dentegra Provider will be made directly to the dentist. Any other payments provided by the Policy will be made to you,unless you request in writing when filing a proof of claim that the payment be made directly to the dentist providing the services. All Benefits not paid to the Provider will be payable to you, the Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

## Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by you will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Policy, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the Policy at the same Premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the Premium to reflect your actual circumstances at time of application or to terminate your policy.

## Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Policy, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by this Policy.

## Conformity with State Laws

All legal questions about this Policy will be governed by the state of Tennessee where this Policy was entered into and is to be performed. Any part of this Policy which conflicts with the laws of Tennessee or federal law is hereby amended to conform to the minimum requirements of such laws.

## Third Party Administrator ("TPA")

Dentegra may use the services of a TPA, duly registered under applicable state law, to provide services under this Policy. Any TPA providing such services or receiving such information will enter into a separate Business Associate Agreement with Dentegra providing that the TPA shall meet HIPAA and HITECH requirements of the preservation of protected health information of Pediatric Enrollees.

# RENEWABLE – PREMIUM MAY CHANGE CONDITIONALLY:

The rate of the monthly Premiums will not be increased during the initial Policy Year. You will receive renewal information from the Exchange prior to any applicable open enrollment period. Provided Dentegra continues to make this policy available through the Exchange at the renewal period:

- you may elect to choose this Policy, which is subject to the applicable Premium through the Exchange for this plan at the time of renewal; and

- you may not have to make an election through the Exchange in subsequent open enrollment periods to continue coverage. The Eligible Enrollee should refer to the Exchange rules regarding automatic renewal of coverage.

## Reinstatement

If you do not pay the Premium within the time granted for payment, the Policy will be terminated as of the 31st day of the Premium grace period. See *Grace Period on Late Payments*.

If the Policy is terminated you may re-enroll in the program at the next Open Enrollment Period and the Deductible and maximum applicable to your program will start over. However, the Policy may be reinstated with no break in coverage provided the full Premium due is received by us within 90 days of the date of the past due Premium. The reinstated Policy will have the same rights as before your Policy lapsed, unless a change is made to the Policy in connection with the reinstatement. These changes, if any, will be sent to you for you to attach to the Policy.

## Payment Guidelines

We do not pay Dentegra Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Dentegra Provider, you are still responsible for the full cost. If the payment is denied because your Dentegra Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your Dentegra Provider that you were covered under a Dentegra Policy at the time you received the service, you may be responsible for the cost of that service.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, please contact us.

# PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment and any subsidy you receive, if applicable. Premiums are listed on Attachment A. An Eligible Enrollee is responsible for making Premium payments, paying Deductibles and Coinsurance and ensuring the Provider is aware of any other dental coverage he/she carries.
Each Premium is to be paid on or before its due date. A due date is the day following the last day of the period for which the preceding Premium was paid. You may pay your Premium [by[D7] visiting our website at [dentegra.com], or by mailing payment to the address below:

Dentegra Insurance Company
[P.O. Box 660138
Dallas, TX 75266-0138]

## Rate Guarantee

Your initial Premium rate is guaranteed for the first 12 months of your Policy, based upon the new enrollee rates in force at the time of your enrollment. The rate guarantee can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change.

No change in Premiums shall become effective within a Policy Term, unless Dentegra's liability is changed by law or regulation. Such a change may include a state and/or federal mandated change or a new or increased tax, assessment or fee imposed on the amounts payable to, or by, Dentegra under this Policy or any immediately preceding Policy between Dentegra and you. Dentegra would provide written notice to you, and this Policy shall thereby be modified on the date set forth in the notice.

## Changing Payment Options

Payment options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on your new billing period. You can change your payment option [by[D8] visiting our website at [dentegra.com], or by contacting our Customer Service Center toll-free at [877-280-4204].]

## Grace Period on Late Payments

If your Premium payment is not received by the first of the month, a grace period of 90 days will be granted. During the first 31 days of the grace period, the Policy shall continue in force. If premiums are not received by the[31st day of the grace period, claims will be placed on hold until the 90th day of the grace period. If premiums are not received by the 90th day of the grace period, your policy will be terminated as of the 31day of the grace period.

# ADDITIONAL DEFINITIONS FOR PEDIATRIC BENEFITS

**Deductible:** a dollar amount that a Pediatric Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits.

**Eligible Pediatric Enrollee**: a person who is considered to be a Qualified Individual by the Tennessee Federally Facilitated Marketplace Exchange and is eligible for Benefits as described in this Policy.

**Out-of-Pocket Maximum:** the maximum amount that a Pediatric Enrollee must satisfy for covered dental services during the Calendar Year provided a Dentegra Provider is used. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum has been met. The Out-of-Pocket Maximum for Dentegra Providers is shown in Attachment A.

**Patient Pays:** the financial obligation for a Pediatric Enrollee for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

# ELIGIBILITY AND ENROLLMENT FOR PEDIATRIC BENEFITS

## Eligibility Requirement

Eligible Pediatric Enrollees are Qualified Individuals as determined by the Exchange. A Qualified Individual must satisfy the Exchange's requirements regarding:

- Citizenship, status as a national, or otherwise lawfully present in the United States;
- Incarceration;
- Residency.

Eligible Pediatric Enrollees can be:

- Primary Enrollee's dependent children from birth to age 26 and include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of Spouse. Adopted children are eligible from the date of entry into the adoptive home or filing of the petition for adoption, whichever occurs first. If the child is in the custody of the state, coverage will begin at the date of entry of a final decree of adoption. Coverage for an adopted child will continue unless the petition is denied.

## Termination of Coverage

The Primary Enrollee has the right to terminate coverage under this Policy by sending Dentegra or the Exchange written notice of intent to terminate this Policy. The effective date of a requested termination will be fourteen days from the date of Dentegra's receipt of the request for termination. If coverage is termed because the Pediatric Enrollee is covered by Medicaid, the last day of coverage with Dentegra is the day before the new coverage is effective.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date.

The Primary Enrollee may keep this Policy in force by timely payment of the Premiums. However, Dentegra may terminate coverage due to:

- Enrollee no longer eligible through the Exchange;

- if termination is due to loss of eligibility through the Exchange, termination is effective the last day of the month following the month that the Exchange notifies you of lack of eligibility;

- non-payment of Premium:
  - if Premiums are not received by the 90th day of the Premium grace period, your policy will be terminated as of the 31st day of the Premium grace period. See *Grace Period on Late Payments*.
- Fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or the Enrollee applying for this coverage or filing a claim for Benefits;
- Enrollee has reached the age of 19;
- the Enrollee changes to a new pediatric dental policy for Enrollees through Tennessee Federally Facilitated Marketplace Exchange; or
- Dentegra ceasing to renew all Policies issued on this form to residents of the state where you live.

# SELECTING YOUR PROVIDER FOR PEDIATRIC BENEFITS

## Free Choice of Provider

We recognize that many factors affect the choice of Provider and therefore support your right to freedom of choice regarding your Provider. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Provider for your covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider.

**Remember, you enjoy the greatest benefits—including out-of-pocket savings—when you choose a Dentegra Provider.** To take full advantage of your Benefits, we highly recommend you verify a dentist's participation status with Dentegra with your dental office before each appointment. Review this section for an explanation of Dentegra payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

## Locating a Dentegra Provider

You may access information through our website at dentegra.com. You may also call our Customer Service Center and one of our representatives will assist you. We can provide you with information regarding a Provider's network, specialty and office location.

## Choosing a Dentegra Provider

Selecting a Dentegra Provider potentially allows the greatest reduction in Pediatric Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon. Also, the services received from a Dentegra Provider apply towards the Out-of-Pocket Maximum limiting a Pediatric Enrollee's out-of-pocket costs to the amount shown in Attachment A.

## Choosing a Non-Dentegra Provider

If a Provider is a Non-Dentegra Provider, the amount charged may be above that accepted by the Dentegra Providers, and Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply after the Out-of-Pocket Maximum is met. Costs incurred with a Non-Dentegra Provider do not count towards the Out-of-Pocket maximum. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

## Additional Obligations of Dentegra Providers:

- The Dentegra Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Dentegra after satisfaction of the Deductible and Coinsurance, and the Pediatric Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra PPO Provider's Contracted Fees.

## How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form, which most dental offices have available. Dentegra Providers will fill out and submit your claims paperwork for you. Some Non-Dentegra Providers may also provide this service upon your request. If you receive services from a Non-Dentegra Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Claim Form" for more information.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Dentegra Insurance Company

[P.O. Box 1850

Alpharetta, GA 30023-1850]

### Prior Authorizations for Medically Necessary Orthodontia

Orthodontic treatment is covered under Pediatric Benefits, which are shown in Attachments A, B and B-1, only when medically necessary as evidenced by a severe handicapping malocclusion, and prior authorization ("Prior Authorization") is required. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

## ADDITIONAL DEFINITIONS FOR ADULT BENEFITS

**Deductible:** a dollar amount that the Enrollee and/or the Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits.

**Eligible Dependent**: any of the dependents of an Eligible Enrollee who are eligible to enroll for Adult Benefits and who meet the conditions of eligibility.

**Eligible Enrollee**: any individual who meets the conditions of eligibility in this policy.

**Patient Pays:** Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

## ELIGIBILITY AND ENROLLMENT FOR ADULT BENEFITS

### Eligibility Requirement

Eligible Enrollees are Qualified Individuals as determined by the Exchange. A Qualified Individual must satisfy the Exchange's requirements regarding:

- citizenship, status as a national, or otherwise lawfully present in the United States;
- incarceration; or
- residency.

Dependent Enrollees can be:
Eligible Enrollee's Spouse and dependent children to age 26 and include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of Spouse.
A dependent unmarried child 26 years of age or older may continue eligibility if:

- he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;

- he or she is chiefly dependent on the Eligible Employee or Spouse for support; and
- proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Eligible Employee or Spouse for support because of a mental or physical disability that began before he or she reached the limiting age.

## Enrollment Grace Period

There is a period of 10 days from your Effective Date during which you may rescind this Policy and receive a full refund, provided you have not used Benefits under this Policy.

## Termination of Coverage

You have the right to terminate coverage under this Policy by sending Dentegra or the Exchange written notice of intent to terminate this Policy. The effective date of a requested termination will be fourteen days from the date of Dentegra's receipt of the request of termination. If coverage is termed because the Dependent Enrollee is covered by Medicaid, the last day of coverage with Dentegra is the day before the new coverage is effective.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date.

You may keep this Policy in force by timely payment of the Premiums. However, Dentegra may terminate coverage due to:

- Enrollee no longer eligible through the Exchange;
  - if termination is due to loss of eligibility through the Exchange, termination is effective the last day of the month following the month that the Exchange notifies you of lack of eligibility;
- non-payment of Premium:
  - if Premiums are not received by the 90th day of the Premium grace period, your policy will be terminated as of the 31st day of the Premium grace period. See *Grace Period on Late Payments*.
- Fraud or material misrepresentation made by or with the knowledge of the Enrollee applying for this coverage or filing a claim for Benefits;
- the Enrollee changes to a new individual dental policy for Enrollee through Tennessee Federally Facilitated Marketplace Exchange; or
- Dentegra ceasing to renew all Policies issued on this form to residents of the state where you live.

# SELECTING YOUR PROVIDER FOR ADULT BENEFITS

## Free Choice of Provider

We recognize that many factors affect the choice of Provider and therefore support your right to freedom of choice regarding your Provider. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Provider for your covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider.

**Remember, you enjoy the greatest benefits—including out-of-pocket savings—when you choose a Dentegra Provider.** To take full advantage of your Benefits, we highly recommend you verify a dentist's participation status with your dental office before each appointment. Review the section titled "Selecting Your Provider" for an explanation of Dentegra payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

## Locating a Dentegra Provider

You may access information through our website at [dentegra.com]. You may also call our Customer Service Center and one of our representatives will assist you. We can provide you with information regarding a Provider's network, specialty and office location.

## Choosing a Dentegra Provider

Selecting a Dentegra Provider potentially allows the greatest reduction in the Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon.

## Choosing a Non-Dentegra Provider

If a Provider is a Non-Dentegra Provider, the amount charged to Enrollees may be above that accepted by the Dentegra Providers, and Enrollees will still be responsible for coinsurance and balance billed amounts. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

## Additional Obligations of Dentegra Providers:

- The Dentegra Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Dentegra after satisfaction of the Deductible and Coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra PPO Contracted Fees.

## How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form, which most dental offices have available. Dentegra Providers will fill out and submit your claims paperwork for you. Some Non-Dentegra Providers may also provide this service upon your request. If you receive services from a Non-Dentegra Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Claim Form" for more information.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

# NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice is required by law to tell you how Dentegra protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Dentegra receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Dentegra program, and we will notify you of how you can receive a copy of this notice every three years.

## Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Dentegra in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate. These affiliates have also implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

**Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations**

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.
  *For example, Dentegra may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment.
  *For example, Dentegra may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations.
  *For example, Dentegra may use and disclose your PHI to review the quality of care provided by our network of providers.*

**Disclosures Without an Authorization**

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Dentegra may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

**Disclosures Dentegra Makes With Your Authorization**

Dentegra will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Dentegra or by a person requesting your PHI from Dentegra.

**Your Rights Regarding PHI**

**You have the right to request an inspection of and obtain a copy of your PHI.** You may access your PHI by contacting the appropriate Dentegra office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Dentegra may charge a reasonable fee for providing you copies of your PHI. Dentegra will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Dentegra to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Dentegra does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

**You have the right to request a restriction of your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

**You have the right to correct or update your PHI.** This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

**You have the right to request or receive confidential communications from us by alternative means or at a different address.** We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

**You have the right to get this notice by email.** You have the right to get a copy of this notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice.

**Complaints**

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Dentegra has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

**Contact**

You may contact the privacy office at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Dentegra Insurance Company
c/o Office of Compliance
[P.O. Box 1850
Alpharetta, GA 30023-1850]

Phone: [877-280-4204]

**This notice is effective on and after August 1, 2012.**

# EMPLOYEE NOTICE

# NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

## COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
(2) the insurer was not authorized to do business in this state;
(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) any policy of reinsurance (unless an assumption certificate was issued);
(3) interest rate yields that exceed an average rate;
(4) dividends;
(5) credits given in connection with the administration of a policy by a group contract holder;
(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
(7) unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

## LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**Tennessee Life and Health Insurance Guaranty Association 150 3rd Avenue South, Suite 1600 Nashville, TN 37201**

**Tennessee Department of Commerce and Insurance 500 James Robertson Parkway Nashville,Tennessee 37243**

# Attachment A
# Deductibles, Maximums and Policy Benefit Levels for Pediatric Benefits
# Dentegra Dental PPO
# Children's Plan 85

**Primary Enrollee: [Name]**

**Effective Date: [XXXXX]**

**Policy ID Number: [XXXX]**

**Premium:** [Per[D1] Pediatric Enrollee:] [$ X[D2]XXX]

***Premiums are to be remitted [monthly][D3] to:***
**Dentegra Insurance Company**
[Street[D4] PO Box 660138
Dallas, TX 75266-0138]

You have a Calendar Year plan and Deductibles and Out-of-Pocket maximums will be based upon a Calendar Year. If you enroll mid-year due to a Qualifying Status Change, your Policy Year will be shorter than 12 months and will begin again on January 1.

**Annual Deductible**
$25 per Pediatric Enrollee each Calendar Year
The annual Deductible will be waived for Diagnostic and Preventive Services.

**Annual Out-of-Pocket Maximum for Dentegra PPO Providers***
Individual $700 each Calendar Year
Multiple Child $1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount that a Pediatric Enrollee must satisfy for covered services under the Policy during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If a Primary Enrollee covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services provided by Dentegra PPO Providers.

| **Policy Benefit Levels** | | |
|---|---|---|
| **Dental Service Category** | **Dentegra PPO Providers†** | **Non-Dentegra Providers†** |
| Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for the following services: | | |
| **Diagnostic and Preventive Services** | 100% | 100% |
| **Basic Services** | 80% | 80% |
| **Major Services** | 50% | 50% |
| **Medically Necessary Orthodontic Services (requires Prior Authorization)** | 50% | 50% |

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

# Attachment A
# Deductibles, Maximums and Policy Benefit Levels for Pediatric Benefits
# Dentegra Dental PPO
# Children's Plan 70

**Primary Enrollee: [Name]**

**Effective Date: [XXXXX]**

**Policy ID Number: [XXXX]**

**Premium:** [Per[D1] Pediatric Enrollee:] [$ X[D2]XXX]

***Premiums are to be remitted [monthly][D3] to:***
**Dentegra Insurance Company**
[Street[D4] PO Box 660138
Dallas, TX 75266-0138]

You have a Calendar Year plan and Deductibles and Out-of-Pocket maximums will be based upon a Calendar Year. If you enroll mid-year due to a Qualifying Status Change, your Policy Year will be shorter than 12 months and will begin again on January 1.

**Annual Deductible**
$45 per Pediatric Enrollee each Calendar Year

**Annual Out-of-Pocket Maximum for Dentegra PPO Providers***
Individual $700 each Calendar Year
Multiple Child $1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount that a Pediatric Enrollee must satisfy for covered services under the Policy during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If a Primary Enrollee covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services provided by Dentegra PPO Providers.

| **Policy Benefit Levels** | | |
|---|---|---|
| **Dental Service Category** | **Dentegra PPO Providers†** | **Non-Dentegra Providers†** |
| Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for the following services: | | |
| **Diagnostic and Preventive Services** | 100% | 100% |
| **Basic Services** | 50% | 50% |
| **Major Services** | 50% | 50% |
| **Medically Necessary Orthodontic Services (requires Prior Authorization)** | 50% | 50% |

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

# Attachment B
# Services, Limitations and Exclusions for Pediatric Benefits
# Dentegra PPO
# Children's Plan [85/70[D1]]

## *Description of Dental Services*

Dentegra will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for the services shown on Attachment B-1 when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthdontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a Prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

## *Limitations*

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

(3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(4) Dentegra will pay for oral examinations (except exams for observation) no more than twice in a Calendar Year. Only one (1) comprehensive evaluation is allowed in a Calendar Year and counts toward the oral examination frequency in the year provided. One (1) limited oral evaluation, problem-focused no more than once in a Calendar Year.

(5) X-ray limitations:
- a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
- b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
- c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
- d) A complete intraoral series and panoramic film are each limited to once every 60 months.
- e) Bitewing x-rays are limited to two (2) times in a Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(6) Dentegra will pay for routine cleanings and topical application of fluoride solutions no more than twice in a Calendar Year, and periodontal cleanings in the presence of inflamed gums up to four (4) times in a Calendar Year. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings not to exceed four (4) procedures or any combination thereof in a Calendar Year. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

(7) Space maintainer limitations:
- a) Space maintainers are limited to the initial appliance.
- b) Recementation of space maintainer is limited to once per lifetime.

c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(8) Sealants are limited as follows:
a) to permanent molars through age 18 if they are without caries (decay) or restorations on the occlusal surface.
b) do not include repair or replacement of a Sealant on any tooth within 36 months of its application.

(9) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.

(10) Dentegra will not cover to replace an amalgam or resin-based composite within 24 months of treatment if the service is provided by the same Provider/Provider office. Pefabricated stainless steel crowns are limited to once per Enrollee per tooth per lifetime. Replacement restorations within 24 months are included in the fee for the original restoration.

(11) Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 15.

(12) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only. It is a benefit for primary incisor teeth up to age six (6) and for primary molars and cuspids to age 11.

(13) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(14) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

(15) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(16) Retrograde fillings per root are limited to once in any 24-month period.

(17) Pin retention is covered not more than once in any 24-month period.

(18) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(19) Periodontal limitations:
a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.
b) Periodontal surgery in the same quadrant is limited to once in every 24-month period and includes any surgical re-entry or scaling and root planing.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
d) If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
f) One crown lengthening per tooth per lifetime.

(20) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(21) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Dentegra determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(22) When an alternate Benefit of an amalgam is allowed for inlays/ onlays, they are limited to Enrollees age 12 and older and are covered not more than once in any 60 month period.

(23) Core buildup, including any pins, are covered not more than once in any 60 month period.

(24) Post and core services are covered not more than once in any 60 month year period.

(25) Crown repairs are covered not more than once in any 60 month period.

(26) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(27) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(28) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Dentegra program will be replaced only after 60 months have passed, except when Dentegra determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Removable cast base partial dentures are limited to Enrollees age 12 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if Dentegra determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.

(29) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(30) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a (6) month period by the same Provider/Provider office.

(31) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Dentegra plan or Enrollee's prior plan, if applicable

(32) Dentegra limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
   a) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
   b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments and relining are limited to one (1) per arch in a 36-month period.
   c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
   d) Recementation of fixed partial dentures is limited to once in a lifetime.

(33) Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period.

(34) Athletic mouth guards are limited to one (1) per 12 consecutive month period.

(35) Internal bleaching of discolored teeth shall not be provided for any tooth more than once each 36 months while the patient is an Enrollee under any Dentegra plan.

### *Exclusions*

**Dentegra does not pay Benefits for:**

(1) services not included on Attachment B-1 Schedule of Covered Services except medically necessary Orthodontics provided a Prior Authorization is obtained.

(2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) cosmetic surgery or procedures for purely cosmetic reasons.

(4) maxillofacial prosthetics.

(5) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under).

(6) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

(7) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.

(8) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(9) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(10) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures if such procedures included in Attachment B-1.

(11) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(12) laboratory processed crowns for Enrollees under age 12.

(13) fixed bridges and removable partials for Enrollees under age 16.

(14) indirectly fabricated resin-based Inlays/Onlays.

(15) overdentures.

(16) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(17) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(18) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(19) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(20) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(21) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.

(22) Deductibles and/or any service not covered under the dental plan.

(23) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(24) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Policy or was covered under any dental care plan with Dentegra or the Enrollee's prior dental plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(25) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(26) endodontic endosseous implant.

# Attachment B-1
# Schedule of Covered Services and Limitations

***Please note the following:***

• Dentegra will pay Benefits for dental services described in this attachment when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

• Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

• The codes and nomenclature in this Schedule are copyright of the American Dental Association. This table represents codes and nomenclature excerpted from the version of Current Dental Terminology (CDT)© in effect at the date of this printing. Dentegra's administration of benefits, limitations and exclusions under this plan at all times will be based on the current version of CDT whether or not a revised table is provided.

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| D&P | D0120 | Periodic oral evaluation - established patient | 2 in a calendar year |
| D&P | D0140 | Limited oral evaluation - problem focused | 1 in a calendar year |
| D&P | D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | |
| D&P | D0150 | Comprehensive oral evaluation - new or established patient | 1 in a calendar year |
| D&P | D0160 | Detailed and extensive oral evaluation - problem focused, by report | problem focused, by report |
| D&P | D0180 | Comprehensive periodontal evaluation - new or established patient | 2 in a calendar year |
| D&P | D0210 | Intraoral - complete series of radiographic images | Limited to 1 every 5 years |
| D&P | D0220 | Intraoral - periapical first radiographic image | |
| D&P | D0230 | Intraoral - periapical each additional radiographic image | |
| D&P | D0240 | Intraoral - occlusal radiographic image | |
| D&P | D0250 | Extraoral - first radiographic image | |
| D&P | D0260 | Extraoral - each additional radiographic image | |
| D&P | D0270 | Bitewing - single radiographic image | |
| D&P | D0272 | Bitewings - two radiographic images | 2 in a calendar year |
| D&P | D0273 | Bitewings - three radiographic images | 2 in a calendar year |
| D&P | D0274 | Bitewings - four radiographic images | 2 in a calendar year |
| D&P | D0277 | Vertical bitewings - 7 to 8 radiographic images | |
| D&P | D0330 | Panoramic radiographic image | |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| D&P | D0425 | Caries susceptibility tests | |
| D&P | D1110 | Prophylaxis - adult | 2 in a calendar year |
| D&P | D1120 | Prophylaxis - child | 2 in a calendar year |
| D&P | D1206 | Topical application of fluoride varnish | |
| D&P | D1208 | Topical application of fluoride | 2 in a calendar year |
| D&P | D1351 | Sealant - per tooth | 1 per tooth every 36 months |
| D&P | D1352 | Preventive resin restoration in a moderate to high caries risk patient - permanent tooth | |
| D&P | D1510 | Space maintainer - fixed - unilateral | |
| D&P | D1515 | Space maintainer - fixed - bilateral | |
| D&P | D1520 | Space maintainer - removable - unilateral | |
| D&P | D1525 | Space maintainer - removable - bilateral | |
| D&P | D1550 | Re-cementation of space maintainer | |
| Basic | D2140 | Amalgam - one surface, primary or permanent | 1 every 24 month period |
| Basic | D2150 | Amalgam - two surfaces, primary or permanent | 1 every 24 month period |
| Basic | D2160 | Amalgam - three surfaces, primary or permanent | 1 every 24 month period |
| Basic | D2161 | Amalgam - four or more surfaces, primary or permanent | 1 every 24 month period |
| Basic | D2330 | Resin-based composite - one surface, anterior | 1 every 24 month period |
| Basic | D2331 | Resin-based composite - two surfaces, anterior | 1 every 24 month period |
| Basic | D2332 | Resin-based composite - three surfaces, anterior | 1 every 24 month period |
| Basic | D2335 | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | 1 every 24 month period |
| Basic | D2391 | Resin-based composite - one surface, posterior | 1 every 24 month period |
| Basic | D2392 | Resin-based composite - two surfaces, posterior | 1 every 24 month period |
| Basic | D2393 | Resin-based composite - three surfaces, posterior | 1 every 24 month period |
| Basic | D2394 | Resin-based composite - four or more surfaces, posterior | 1 every 24 month period |
| Major | D2510 | Inlay - metallic - one surface | |
| Major | D2520 | Inlay - metallic - two surfaces | |
| Major | D2530 | Inlay - metallic - three or more surfaces | |
| Major | D2542 | Onlay - metallic-two surfaces | Limited to 1 every 5 years |
| Major | D2543 | Onlay - metallic-three surfaces | Limited to 1 every 5 years |
| Major | D2544 | Onlay - metallic-four or more surfaces | Limited to 1 every 5 years |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D2740 | Crown - porcelain/ceramic substrate | |
| Major | D2750 | Crown - porcelain fused to high noble metal | Limited to 1 every 5 years |
| Major | D2751 | Crown - porcelain fused to predominantly base metal | Limited to 1 every 5 years |
| Major | D2752 | Crown - porcelain fused to noble metal | Limited to 1 every 5 years |
| Major | D2780 | Crown - 3/4 cast high noble metal | Limited to 1 every 5 years |
| Major | D2781 | Crown - 3/4 cast predominantly base metal | Limited to 1 every 5 years |
| Major | D2782 | Crown - 3/4 cast noble metal | Limited to 1 every 5 years |
| Major | D2783 | Crown - 3/4 porcelain/ceramic | Limited to 1 every 5 years |
| Major | D2790 | Crown - full cast high noble metal | Limited to 1 every 5 years |
| Major | D2791 | Crown - full cast predominantly base metal | Limited to 1 every 5 years |
| Major | D2792 | Crown - full cast noble metal | Limited to 1 every 5 years |
| Major | D2794 | Crown - titanium | Limited to 1 every 5 years |
| Major | D2910 | Recement inlay, onlay, or partial coverage restoration | Once per 6-month period |
| Major | D2920 | Recement crown | Once per 6-month period |
| Basic | D2930 | Prefabricated stainless steel crown - primary tooth | |
| Basic | D2931 | Prefabricated stainless steel crown - permanent tooth | |
| Major | D2950 | Core buildup, including any pins | Limited to 1 every 5 years |
| Major | D2951 | Pin retention - per tooth, in addition to restoration | Limited to 1 every 24 months |
| Major | D2954 | Prefabricated post and core in addition to crown | Limited to 1 every 5 years |
| Major | D2980 | Crown repair necessitated by restorative material failure | |
| Major | D2981 | Inlay repair necessitated by restorative material failure | |
| Major | D2982 | Onlay repair necessitated by restorative material failure | |
| Major | D2983 | Veneer repair necessitated by restorative material failure | |
| Basic | D2990 | Resin infiltration of incipient smooth surface lesions | |
| Major | D3110 | Pulp cap - direct (excluding final restoration) | |
| Major | D3120 | Pulp cap - indirect (excluding final restoration) | |
| Major | D3220 | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | |
| Major | D3221 | Pulpal debridement, primary and permanent teeth | |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D3222 | Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | |
| Major | D3230 | Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | |
| Major | D3240 | Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | |
| Major | D3310 | Endodontic therapy, anterior tooth (excluding final restoration) | |
| Major | D3320 | Endodontic therapy, bicuspid tooth (excluding final restoration) | |
| Major | D3330 | Endodontic therapy, molar (excluding final restoration) | |
| Major | D3346 | Retreatment of previous root canal therapy - anterior | |
| Major | D3347 | Retreatment of previous root canal therapy - bicuspid | |
| Major | D3348 | Retreatment of previous root canal therapy - molar | |
| Major | D3351 | Apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) | |
| Major | D3352 | Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) | |
| Major | D3353 | Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | |
| Major | D3354 | Pulpal regeneration - (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration | |
| Major | D3410 | Apicoectomy/periradicular surgery - anterior | |
| Major | D3421 | Apicoectomy/periradicular surgery - bicuspid (first root) | |
| Major | D3425 | Apicoectomy/periradicular surgery - molar (first root) | |
| Major | D3426 | Apicoectomy/periradicular surgery (each additional root) | |
| Major | D3430 | Retrograde filling - per root | |
| Major | D3450 | Root amputation - per root | |
| Major | D3920 | Hemisection (including any root removal), not including root canal therapy | |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | Limited to 1 every 24 months |
| Major | D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | Limited to 1 every 24 months |
| Major | D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | Limited to 1 every 24 months |
| Major | D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | Limited to 1 every 24 months |
| Major | D4241 | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | Limited to 1 every 24 months |
| Major | D4249 | Clinical crown lengthening - hard tissue | |
| Major | D4260 | Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | Limited to 1 every 24 months |
| Major | D4261 | Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | Limited to 1 every 24 months |
| Major | D4268 | Surgical revision procedure, per tooth | |
| Major | D4270 | Pedicle soft tissue graft procedure | |
| Major | D4273 | Subepithelial connective tissue graft procedures, per tooth | |
| Major | D4275 | Soft tissue allograft | |
| Major | D4276 | Combined connective tissue and double pedicle graft, per tooth | |
| Major | D4277 | Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft | |
| Major | D4278 | Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site | |
| Major | D4341 | Periodontal scaling and root planing - four or more teeth per quadrant | Limited to 1 every 24 months |
| Major | D4342 | Periodontal scaling and root planing - one to three teeth per quadrant | Limited to 1 every 24 months |
| Basic | D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis | Limited to 1 per lifetime |
| Major | D4381 | Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth | |
| Basic | D4910 | Periodontal maintenance | Up to 4 periodontal maintenance procedures and up to 2 routine cleanings not to exceed 4 |
| Major | D5110 | Complete denture - maxillary | Limited to 1 every 5 years |
| Major | D5120 | Complete denture - mandibular | Limited to 1 every 5 years |
| Major | D5130 | Immediate denture - maxillary | Limited to 1 every 5 years |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D5140 | Immediate denture - mandibular | Limited to 1 every 5 years |
| Major | D5211 | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) | Limited to 1 every 5 years |
| Major | D5212 | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | Limited to 1 every 5 years |
| Major | D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | Limited to 1 every 5 years |
| Major | D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | Limited to 1 every 5 years |
| Major | D5281 | Removable unilateral partial denture - one piece cast metal (including clasps and teeth) | Limited to 1 every 5 years |
| Major | D5410 | Adjust complete denture - maxillary | |
| Major | D5411 | Adjust complete denture - mandibular | |
| Major | D5421 | Adjust partial denture - maxillary | |
| Major | D5422 | Adjust partial denture - mandibular | |
| Major | D5510 | Repair broken complete denture base | |
| Major | D5520 | Replace missing or broken teeth - complete denture (each tooth) | |
| Major | D5610 | Repair resin denture base | |
| Major | D5620 | Repair cast framework | |
| Major | D5630 | Repair or replace broken clasp | |
| Major | D5640 | Replace broken teeth - per tooth | |
| Major | D5650 | Add tooth to existing partial denture | |
| Major | D5660 | Add clasp to existing partial denture | |
| Major | D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | |
| Major | D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | |
| Major | D5710 | Rebase complete maxillary denture | Limited to 1 in a 36-months |
| Major | D5711 | Rebase complete mandibular denture | Limited to 1 in a 36-months |
| Major | D5720 | Rebase maxillary partial denture | Limited to 1 in a 36-months |
| Major | D5721 | Rebase mandibular partial denture | Limited to 1 in a 36-months |
| Major | D5730 | Reline complete maxillary denture (chairside) | Limited to 1 in a 36-months |
| Major | D5731 | Reline complete mandibular denture (chairside) | Limited to 1 in a 36-months |
| Major | D5740 | Reline maxillary partial denture (chairside) | Limited to 1 in a 36-months |
| Major | D5741 | Reline mandibular partial denture (chairside) | Limited to 1 in a 36-months |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D5750 | Reline complete maxillary denture (laboratory) | Limited to 1 in a 36-months |
| Major | D5751 | Reline complete mandibular denture (laboratory) | Limited to 1 in a 36-months |
| Major | D5760 | Reline maxillary partial denture (laboratory) | Limited to 1 in a 36-months |
| Major | D5761 | Reline mandibular partial denture (laboratory) | Limited to 1 in a 36-months |
| Major | D5850 | Tissue conditioning, maxillary | |
| Major | D5851 | Tissue conditioning, mandibular | |
| Major | D6010 | Surgical placement of implant body: endosteal implant | Limited to 1 every 5 years |
| Major | D6053 | Implant/abutment supported removable denture for completely edentulous arch | Limited to 1 every 5 years |
| Major | D6054 | Implant/abutment supported removable denture for partially edentulous arch | Limited to 1 every 5 years |
| Major | D6055 | Connecting bar - implant supported or abutment supported | Limited to 1 every 5 years |
| Major | D6056 | Prefabricated abutment - includes modification and placement | Limited to 1 every 5 years |
| Major | D6057 | Custom fabricated abutment - includes placement | Limited to 1 every 5 years |
| Major | D6058 | Abutment supported porcelain/ceramic crown | Limited to 1 every 5 years |
| Major | D6059 | Abutment supported porcelain fused to metal crown (high noble metal) | Limited to 1 every 5 years |
| Major | D6060 | Abutment supported porcelain fused to metal crown (predominantly base metal) | Limited to 1 every 5 years |
| Major | D6061 | Abutment supported porcelain fused to metal crown (noble metal) | Limited to 1 every 5 years |
| Major | D6062 | Abutment supported cast metal crown (high noble metal) | Limited to 1 every 5 years |
| Major | D6063 | Abutment supported cast metal crown (predominantly base metal) | Limited to 1 every 5 years |
| Major | D6064 | Abutment supported cast metal crown (noble metal) | Limited to 1 every 5 years |
| Major | D6065 | Implant supported porcelain/ceramic crown | Limited to 1 every 5 years |
| Major | D6066 | Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) | Limited to 1 every 5 years |
| Major | D6067 | Implant supported metal crown (titanium, titanium alloy, high noble metal) | Limited to 1 every 5 years |
| Major | D6068 | Abutment supported retainer for porcelain/ceramic FPD | Limited to 1 every 5 years |
| Major | D6069 | Abutment supported retainer for porcelain fused to metal FPD (high noble metal) | Limited to 1 every 5 years |
| Major | D6070 | Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) | Limited to 1 every 5 years |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D6071 | Abutment supported retainer for porcelain fused to metal FPD (noble metal) | Limited to 1 every 5 years |
| Major | D6072 | Abutment supported retainer for cast metal FPD (high noble metal) | Limited to 1 every 5 years |
| Major | D6073 | Abutment supported retainer for cast metal FPD (predominantly base metal) | Limited to 1 every 5 years |
| Major | D6074 | Abutment supported retainer for cast metal FPD (noble metal) | Limited to 1 every 5 years |
| Major | D6075 | Implant supported retainer for ceramic FPD | Limited to 1 every 5 years |
| Major | D6076 | Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) | Limited to 1 every 5 years |
| Major | D6077 | Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) | Limited to 1 every 5 years |
| Major | D6078 | Implant/abutment supported fixed denture for completely edentulous arch | Limited to 1 every 5 years |
| Major | D6079 | Implant/abutment supported fixed denture for partially edentulous arch | Limited to 1 every 5 years |
| Major | D6080 | Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis | Limited to 1 every 5 years |
| Major | D6090 | Repair implant supported prosthesis, by report | Limited to 1 every 5 years |
| Major | D6091 | Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment | Limited to 1 every 5 years |
| Major | D6094 | Abutment supported crown - (titanium) | Limited to 1 every 5 years |
| Major | D6095 | Repair implant abutment, by report | Limited to 1 every 5 years |
| Major | D6100 | Implant removal, by report | Limited to 1 every 5 years |
| Major | D6194 | Abutment supported retainer crown for FPD - (titanium) | Limited to 1 every 5 years |
| Major | D6210 | Pontic - cast high noble metal | Limited to 1 every 5 years |
| Major | D6211 | Pontic - cast predominantly base metal | Limited to 1 every 5 years |
| Major | D6212 | Pontic - cast noble metal | Limited to 1 every 5 years |
| Major | D6214 | Pontic - titanium | Limited to 1 every 5 years |
| Major | D6240 | Pontic - porcelain fused to high noble metal | Limited to 1 every 5 years |
| Major | D6241 | Pontic - porcelain fused to predominantly base metal | Limited to 1 every 5 years |
| Major | D6242 | Pontic - porcelain fused to noble metal | Limited to 1 every 5 years |
| Major | D6245 | Pontic - porcelain/ceramic | Limited to 1 every 5 years |
| Major | D6545 | Retainer - cast metal for resin bonded fixed prosthesis | Limited to 1 every 5 years |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D6548 | Retainer - porcelain/ceramic for resin bonded fixed prosthesis | Limited to 1 every 5 years |
| Major | D6601 | Inlay - porcelain/ceramic, three or more surfaces | Limited to 1 every 5 years |
| Major | D6604 | Inlay - cast predominantly base metal, two surfaces | Limited to 1 every 5 years |
| Major | D6605 | Inlay - cast predominantly base metal, three or more surfaces | Limited to 1 every 5 years |
| Major | D6613 | Onlay - cast predominantly base metal, three or more surfaces | Limited to 1 every 5 years |
| Major | D6740 | Crown - porcelain/ceramic | Limited to 1 every 5 years |
| Major | D6750 | Crown - porcelain fused to high noble metal | Limited to 1 every 5 years |
| Major | D6751 | Crown - porcelain fused to predominantly base metal | Limited to 1 every 5 years |
| Major | D6752 | Crown - porcelain fused to noble metal | Limited to 1 every 5 years |
| Major | D6780 | Crown - 3/4 cast high noble metal | Limited to 1 every 5 years |
| Major | D6781 | Crown - 3/4 cast predominantly based metal | Limited to 1 every 5 years |
| Major | D6782 | Crown - 3/4 cast noble metal | Limited to 1 every 5 years |
| Major | D6783 | Crown - 3/4 porcelain/ceramic | Limited to 1 every 5 years |
| Major | D6790 | Crown - full cast high noble metal | Limited to 1 every 5 years |
| Major | D6791 | Crown - full cast predominantly base metal | Limited to 1 every 5 years |
| Major | D6792 | Crown - full cast noble metal | Limited to 1 every 5 years |
| Major | D6794 | Crown - titanium | Limited to 1 every 5 years |
| Major | D6930 | Recement fixed partial denture | |
| Major | D6980 | Fixed partial denture repair necessitated by restorative material failure | |
| Major | D7111 | Extraction, coronal remnants - deciduous tooth | |
| Major | D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | |
| Major | D7210 | Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | |
| Major | D7220 | Removal of impacted tooth - soft tissue | |
| Major | D7230 | Removal of impacted tooth - partially bony | |
| Major | D7240 | Removal of impacted tooth - completely bony | |
| Major | D7241 | Removal of impacted tooth - completely bony, with unusual surgical complications | |
| Major | D7250 | Surgical removal of residual tooth roots (cutting procedure) | |
| Major | D7251 | Coronectomy - intentional partial tooth removal | |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | |
| Major | D7280 | Surgical access of an unerupted tooth | |
| Major | D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | |
| Major | D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | |
| Major | D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | |
| Major | D7321 | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | |
| Major | D7471 | Removal of lateral exostosis (maxilla or mandible) | |
| Major | D7510 | Incision and drainage of abscess - intraoral soft tissue | |
| Major | D7910 | Suture of recent small wounds up to 5 cm | |
| Major | D7921 | Collection and application of autologous blood concentrate product | |
| Major | D7971 | Excision of pericoronal gingiva | |
| Major | D7999 | Unspecified oral surgery procedure, by report | |
| Basic | D9110 | Palliative (emergency) treatment of dental pain - minor procedure | |
| Basic | D9220 | Deep sedation/general anesthesia - first 30 minutes | |
| Basic | D9221 | Deep sedation/general anesthesia - each additional 15 minutes | |
| Basic | D9241 | Intravenous conscious sedation/analgesia - first 30 minutes | |
| Basic | D9242 | Intravenous conscious sedation/analgesia - each additional 15 minutes | |
| D&P | D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | 1 per lifetime |
| Basic | D9440 | Office visit - after regularly scheduled hours | |
| Basic | D9610 | Therapeutic parenteral drug, single administration | |
| Basic | D9612 | Therapeutic parenteral drugs, two or more administrations, different medications | |
| Basic | D9930 | Treatment of complications (post-surgical) - unusual circumstances, by report | |
| Major | D9940 | Occlusal guard, by report | 1 in 12 months for patients 13 and older |

| Category | Procedure Code | Procedure Description | Limitations |
|---|---|---|---|
| Major | D9941 | Fabrication of athletic mouthguard | |
| Major | D9974 | Internal bleaching - per tooth | |
| Major | D9999 | Unspecified adjunctive procedure, by report | |

**Attachment C**
**Deductibles, Maximums and Policy Benefit Levels for Adult Benefits**
**Dentegra Dental PPO**
**Adult Preferred**

**Primary Enrollee: [Name]**

**Effective Date: [XXXXX]**

**Policy ID Number: [XXXX]**

**Premium:** [Per[D1] Enrollee:] [$ X[D2]XXX]

***Premiums are to be remitted [monthly]***[D3] ***to:***
Dentegra Insurance Company
[Street[D4] PO Box 660138
Dallas, TX 75266-0138]

You have a Calendar Year plan and Deductibles and Maximums will be based upon a Calendar Year. If you enroll mid-year due to a Qualifying Status Change, your Policy Year will be shorter than 12 months and will begin again on January 1.

| Deductibles & Maximums | |
|---|---|
| **Annual Deductible** | $50 per Enrollee each Calendar Year<br>$150 per family each Calendar Year |
| Deductibles waived for | Diagnostic & Preventive |
| **Annual Maximum** | $1,000 per Enrollee per Calendar Year |
| **Dental Accident Maximum** | $1,000 per Enrollee per lifetime |

| Policy Benefit Levels | | |
|---|---|---|
| **Dental Service Category** | **Dentegra PPO Provider**† | **Non-Dentegra Providers**† |
| Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for the following services: | | |
| **Diagnostic & Preventive** | 100% | 100% |
| **Basic Restorative** | 80% | 80% |
| **Major Services** | 50% | 50% |
| **Dental Accident** | 100% | 100% |

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

## Waiting Periods:

- Major Services are limited to Enrollees who have been enrolled in the Policy for 12 consecutive months. Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date of Coverage reported by the Exchange for said Primary Enrollee and/or Dependent Enrollee.

# Attachment C
# Deductibles, Maximums and Policy Benefit Levels for Adult Benefits
# Dentegra Dental PPO
# Adult Basic

**Primary Enrollee: [Name]**

**Effective Date: [XXXXX]**

**Policy ID Number: [XXXX]**

**Premium:** [Per[D1] Enrollee:] [$ X[D2]XXX]

***Premiums are to be remitted [monthly]***[D3] ***to:***
Dentegra Insurance Company
[Street[D4] PO Box 660138
Dallas, TX 75266-0138]

You have a Calendar Year plan and Deductibles and Maximums will be based upon a Calendar Year. If you enroll mid-year due to a Qualifying Status Change, your Policy Year will be shorter than 12 months and will begin again on January 1.

| Deductibles & Maximums | |
|---|---|
| **Annual Deductible** | $50 per Enrollee each Calendar Year<br>$150 per family each Calendar Year |
| Deductibles waived for | Diagnostic & Preventive |
| **Annual Maximum** | $1,000 per Enrollee per Calendar Year |

| Policy Benefit Levels | | |
|---|---|---|
| **Dental Service Category** | **Dentegra PPO Provider**† | **Non-Dentegra Providers**† |
| Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for the following services: | | |
| **Diagnostic & Preventive** | 100% | 100% |
| **Basic Restorative** | 80% | 80% |

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

# Attachment D
# Services, Limitations and Exclusions for Adult Benefits
# Dentegra Dental PPO
# Adult Preferred

## *Description of Dental Services*

Dentegra will pay or otherwise discharge the Policy Benefit Level shown in Attachment C for the following services:

- **Diagnostic and Preventive Services**
  - (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
  - (2) Preventive: cleaning (periodontal cleaning in the presence of inflamed gums is considered to be a Basic Service for payment purposes).
  - (3) Specialist Consultations: opinion or advice requested by a general dentist.
- **Basic Services**
  - (1) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
  - (2) Palliative: emergency treatment to relieve pain.
  - (3) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
  - (4) Periodontal Cleanings: periodontal maintenance.
- **Major Services**
  - (1) Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
  - (2) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
  - (3) Oral Surgery: extractions and certain other surgical procedures (including pre-and post-operative care).
  - (4) Endodontics: treatment of diseases and injuries of the tooth pulp.
  - (5) Periodontics: treatment of gums and bones supporting teeth.
  - (6) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
- **Dental Accident Services**
  An injury to the mouth or structures within the oral cavity which is caused by an external traumatic force. It does not include damage to the teeth which is the result of biting into food or other substances. Procedures shall include, but are not limited to, reimplantation, splinting and stayplate.
- ***Note on additional Benefits during pregnancy***
  When an Enrollee is pregnant, Dentegra will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

***Limitations***

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services”. Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:
a) a composite restoration instead of an amalgam restoration on posterior teeth;
b) a crown where a filling would restore the tooth;
c) an inlay/onlay instead of an amalgam restoration; or
d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Dentegra will pay for oral examinations (except afterhours exams and exams for observation) and cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) no more than twice in a Calendar Year**.** A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.

(3) X-ray limitations:
a) Dentegra will limit the total reimbursable amount to the Provider’s Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider’s Accepted Fee for a complete intraoral series.
c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
d) A complete intraoral series and panoramic film are each limited to once every 60 months.
e) Bitewing x-rays are limited to one (1) time each Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(4) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(5) Specialist Consultations, screenings of patients, and assessments of patients are limited to once per lifetime per Provider and count toward the oral exam frequency.

(6) Dentegra will not cover to replace an amalgam, resin-based composite or prefabricated stainless steel crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.

(7) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

(8) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(9) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(10) Pin retention is covered not more than once in any 24-month period.

(11) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(12) Periodontal limitations:
a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy.
b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

d) If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.

(13) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(14) Crowns and Inlays/Onlays are covered not more often than once in any 60 month period except when Dentegra determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(15) When an alternate Benefit of an amalgam is allowed for inlays/ onlays, they are covered not more than once in any 60 month period.

(16) Core buildup, including any pins, are covered not more than once in any 60 month period.

(17) Post and core services are covered not more than once in any 60 month year period.

(18) Crown repairs are covered not more than once in any 60 month period.

(19) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(20) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(21) Prosthodontic appliances implants and/or implant supported prosthetics that were provided under any Dentegra program will be replaced only after 60 months have passed, except when Dentegra determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if Dentegra determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.

(22) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(23) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

(24) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Dentegra plan or Contractholder's prior plan, if applicable.

(25) Dentegra limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.
c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
d) Recementation of fixed partial dentures is limited to once in a lifetime.

(26) Limitations on Dental Accident Services:
a) The dental accident must occur while the Enrollee is covered under the Policy.

b) Services and procedures must be provided within 180 days following the dental accident and while the Enrollee is covered under the Policy.

### *Exclusions*

**Dentegra does not pay Benefits for:**

(1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(2) cosmetic surgery or procedures for purely cosmetic reasons.

(3) maxillofacial prosthetics.

(4) provisional and/or temporary restorations.

(5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

(6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.

(7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(9) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected endodontic and periodontal surgical procedures.

(10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(11) interim implants.

(12) indirectly fabricated resin-based Inlays/Onlays.

(13) overdentures.

(14) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(15) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(16) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(17) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(18) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(19) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.

(20) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(21) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(22) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Policy or was covered under any dental care plan with Dentegra or the Contractholder's prior dental plan, if

applicable. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(23) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.

(24) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues).

(25) endodontic endosseous implant.

(26) services or supplies for sealants, fluoride, space maintainers, apexification and transseptal fiberotomy/supra crestal fiberotomy.

# Attachment D
# Services, Limitations and Exclusions for Adult Benefits
# Dentegra Dental PPO
# Adult Basic

## *Description of Dental Services*

Dentegra will pay or otherwise discharge the Policy Benefit Level shown in Attachment C for the following services:

- **Diagnostic and Preventive Services**
  - (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
  - (2) Preventive: routine cleanings.
  - (3) Specialist Consultations: opinion or advice requested by a general dentist.
- **Basic Services**
  - (1) Palliative: emergency treatment to relieve pain.
  - (2) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- ***Note on additional Benefits during pregnancy***
  When an Enrollee is pregnant, Dentegra will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and one (1) additional routine cleaning. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

## *Limitations*

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. An example of an Optional Service is a composite restoration instead of an amalgam restoration on posterior teeth.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Dentegra will pay for oral examinations (except afterhours exams and exams for observation) and routine cleanings no more than twice in a Calendar Year**.** See note on additional Benefits during pregnancy.

(3) X-ray limitations:
- a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
- b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
- c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
- d) A complete intraoral series and panoramic film are each limited to once every 60 months.
- e) Bitewing x-rays are limited to one (1) time each Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(4) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(5) Specialist Consultations, screenings of patients, and assessments of patients are limited to once per lifetime per Provider and count toward the oral exam frequency.

(6) Dentegra will not cover to replace an amalgam, resin-based composite or prefabricated stainless steel crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.

(7) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

(8) Pin retention is covered not more than once in any 24-month period.

(9) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

### *Exclusions*

**Dentegra does not pay Benefits for:**

(1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(2) cosmetic surgery or procedures for purely cosmetic reasons.

(3) maxillofacial prosthetics.

(4) provisional and/or temporary restorations.

(5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

(6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.

(7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(9) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(10) interim implants.

(11) indirectly fabricated resin-based Inlays/Onlays.

(12) overdentures.

(13) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(14) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(15) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(16) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(17) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(18) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.

(19) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(20) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(21) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.

(22) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(23) endodontic endosseous implant.

(24) services or supplies for sealants, fluoride, space maintainers, apexification and transseptal fiberotomy/supra crestal fiberotomy.

(25) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.

(26) services or supplies for oral surgery, general anesthesia or IV sedation.

(27) services or supplies for endodontic treatment (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).

(28) services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth).

(29) services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining).

(30) services or supplies for crowns and inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, or plastic restorations.

(31) services or supplies for prosthodontics (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges).

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *DDPA-129064431* | ***State Tracking #:*** | *H-130880* | ***Company Tracking #:*** | *DIC, HCR IND PPO TN, FORMS AND RATES* |

| | | | |
|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *Dentegra Insurance Company* |
| ***TOI/Sub-TOI:*** | *H10I Individual Health - Dental/H10I.000 Health - Dental* | | |
| ***Product Name:*** | *DIC, HCR Ind PPO TN, forms and rates* | | |
| ***Project Name/Number:*** | */* | | |

## Rate Information

Rate data applies to filing.

**Filing Method:**

**Rate Change Type:** %

**Overall Percentage of Last Rate Revision:** %

**Effective Date of Last Rate Revision:**

**Filing Method of Last Filing:**

### Company Rate Information

| Company Name: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | # of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where req'd): | Minimum % Change (where req'd): |
|---|---|---|---|---|---|---|---|
| Dentegra Insurance Company | 0.000% | 0.000% | $0 | 0 | $0 | 0.000% | 0.000% |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *DDPA-129064431* | ***State Tracking #:*** | *H-130880* | ***Company Tracking #:*** | *DIC, HCR IND PPO TN, FORMS AND RATES* |

| | | | |
|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *Dentegra Insurance Company* |
| ***TOI/Sub-TOI:*** | *H10I Individual Health - Dental/H10I.000 Health - Dental* | | |
| ***Product Name:*** | *DIC, HCR Ind PPO TN, forms and rates* | | |
| ***Project Name/Number:*** | */* | | |

## Rate/Rule Schedule

| Item No. | Schedule Item Status | Document Name | Affected Form Numbers (Separated with commas) | Rate Action | Rate Action Information | Attachments |
|---|---|---|---|---|---|---|
| 1 | | Actuarial Memorandum | PIP-TN-DIC | New | | Actuarial Memorandum Dentegra TN Pediatric PPO Individual 2013 05 22.pdf, |
| 2 | | Actuarial Memorandum | XIP-TN-DIC | New | | Actuarial Memorandum Dentegra TN Supplemental PPO Individual 2013 05 22.pdf, |

ACTUARIAL MEMORANDUM
Dentegra Insurance Company
State of Tennessee
May 22, 2013

Form Number PIP-TN-DIC

1. **Scope and Purpose of Filing**
   This filing is for the above Dentegra Insurance Company (DIC) forms.

2. **Description of Benefits**

   The pediatric dental EHB are defined in Attachment A and cover essential health benefit services as defined by the state. These comply with the actuarial value requirements for the high and low EHB plans.

3. **Renewability**
   All individual dental programs are optionally renewable. Premiums are guaranteed for each 12-month contract term.

4. **Applicability**
   DIC anticipates both new issues and renewals under these forms.

5. **Morbidity**
   The proposed rates were developed using the Delta Dental Insurance Company (DDIC), NAIC #81396, rating manual, which is currently in use in numerous states. Adjustments have been made to reflect the fee schedules and area definitions associated with this filing.

6. **Mortality**
   Not applicable.

7. **Persistency**
   Loss ratios are expected to be consistent over time. As a result, there are no lapse assumptions.

8. **Expenses**

   Expenses are shown in Attachment B. Co-marketing in conjunction with a medical plan, may require a change in administrative assumptions due to division of labor between medical and dental, cost sharing, etc.

9. **Marketing Method**
   This will be sold to individuals through the Tennessee health exchange or through agents and brokers inside or outside the exchange.

10. **Underwriting**

The plans are manually rated.

11. **Premium Classes**
Gross premiums vary by plan designs illustrated in Attachment A.

12. **Issue Age Range**
Not applicable.

13. **Area Factors**
Manual rates are statewide.

14. **Premium Modalization Rules**
Not applicable since this is a new plan offering.

15. **Claim Liability and Reserves**
This reserve is projected from historical claims runoff, using a common reserving methodology.

16. **Active Life Reserves**
Not applicable since this is a new plan offering.

17. **Trend Assumptions**
The annual cost trend rate is 4%.

18. **Anticipated Loss Ratio**
The anticipated loss ratio is shown in Attachment B.

19. **Distribution of Business**
Not applicable since this is a new plan offering.

20. **Contingency and Risk Margins**
Risk margin is shown in Attachment B.

21. **Experience**
Please see Attachment C for DDIC small group experience.

22. **Lifetime Loss Ratio**
The lifetime loss ratio is equal to the anticipated loss ratio.

23. **Number of Policyholders**
Not applicable since this is a new plan offering.

24. **Proposed Effective Date**
01/01/2014.

**25. Actuarial Certification**

I, Thomas J. Leibowitz, FSA, MAAA, am a member of the American Academy of Actuaries, and meet the Academy Qualification Standard for rendering this Opinion.

I have reviewed the actuarial assumptions and methods on which the rates are based. I hereby certify that to the best of my knowledge and judgment, this rate filing is in compliance with the applicable laws and regulations of the state of Tennessee and complies with Actuarial Standard of Practice No. 8. The rates shown are

- Based on actuarially sound principles
- Are not inadequate, excessive or unfairly discriminatory, and
- Are reasonable in relation to the benefits provided.

Thomas J. Leibowitz, FSA, MAAA
Vice President and Chief Actuary
Dentegra Insurance Company
One First Street
San Francisco, CA 94105

**Attachment A**

**Tennessee Individual Pediatric Dental Benefits**

| PPO/PPO | Pediatric High | Pediatric Low |
|---|---|---|
| Diagnostic & Preventive | 100% | 100% |
| Basic Services | 80% | 50% |
| Major Services | 50% | 50% |
| Orthodontics (Medically Necessary) | 50% | 50% |
| Deductible | | |
| Waived on D&P | yes | no |
| Per Person | $25 | $45 |
| Family | n/a | n/a |
| Annual Maximum | None | None |
| Othodontics Maximum (Lifetime) | None | None |
| Waiting Periods (Major & Ortho) | None | None |
| Out of Pocket Maximum (PPO dentists only) | | |
| per child | $700 | $700 |
| per 2+ children | $1,400 | $1,400 |
| Dental Accident Benefits | NAB* | NAB* |
| **Rates:** Statewide | $32.34 | $26.05 |

* NAB is not a benefit

Note: Covered procedures are defined in the forms

**Attachment B**

**Tennessee Individual Administrative Expenses (as a percent of premium)**

| | Pediatric High | Pediatric Low |
|---|---|---|
| Admin Expenses | 22.50% | 22.50% |
| Risk Margin | 5.50% | 3.00% |
| Premium Tax | 2.50% | 2.50% |
| ACA Tax | 2.00% | 2.00% |
| TPA Admin | 0.00% | 0.00% |
| Commissions | 5.00% | 5.00% |
| Total | 37.50% | 35.00% |
| | | |
| Anticipated Loss Ratio ** | 65.45% | 68.06% |

** Anticipated Loss Ratio = (1 - Total) / (1 - Premium Tax - ACA Tax)

**Attachment C**
**DDIC Small Group Experience**

| | **CY2012** |
|---|---|
| Number of Policy Holders | 2,881 |
| Number of Certificate Holders | 38,308 |
| Earned Premium | $24,525,709 |
| Average Annual Premium | $640 |
| Incurred Claims | $16,016,000 |
| Number of Incurred Claims | 124,033 |
| Incurred Loss Ratio | 65.3% |

ACTUARIAL MEMORANDUM
Dentegra Insurance Company
State of Tennessee
May 22, 2013

Form Number XIP-TN-DIC

1. **Scope and Purpose of Filing**
   This filing is for the above Dentegra Insurance Company (DIC) forms.

2. **Description of Benefits**
   The Supplemental dental plans are defined in Attachment A and cover standardly covered services.

3. **Renewability**
   All individual dental programs are optionally renewable. Premiums are guaranteed for each 12-month contract term.

4. **Applicability**
   DIC anticipates both new issues and renewals under these forms.

5. **Morbidity**
   The proposed rates were developed using the Delta Dental Insurance Company (DDIC), NAIC #81396, rating manual, which is currently in use in numerous states. Adjustments have been made to reflect the fee schedules and area definitions associated with this filing.

6. **Mortality**
   Not applicable.

7. **Persistency**
   Loss ratios are expected to be consistent over time. As a result, there are no lapse assumptions.

8. **Expenses**

   Expenses are shown in Attachment B. Co-marketing in conjunction with a medical plan, may require a change in administrative assumptions due to division of labor between medical and dental, cost sharing, etc.

9. **Marketing Method**
   This will be sold to individuals through the Tennessee health exchange or through agents and brokers inside or outside the exchange.

10. **Underwriting**
    The plans are manually rated.

11. **Premium Classes**
Gross premiums vary by plan designs illustrated in Attachment A.

12. **Issue Age Range**
Not applicable.

13. **Area Factors**
Manual rates are statewide.

14. **Premium Modalization Rules**
Not applicable since this is a new plan offering.

15. **Claim Liability and Reserves**
This reserve is projected from historical claims runoff, using a common reserving methodology.

16. **Active Life Reserves**
Not applicable since this is a new plan offering.

17. **Trend Assumptions**
The annual cost trend rate is 4%.

18. **Anticipated Loss Ratio**
The anticipated loss ratio is shown in Attachment B.

19. **Distribution of Business**
Not applicable since this is a new plan offering.

20. **Contingency and Risk Margins**
Risk margin is shown in Attachment B.

21. **Experience**
Please see Attachment C for DDIC small group experience.

22. **Lifetime Loss Ratio**
The lifetime loss ratio is equal to the anticipated loss ratio.

23. **Number of Policyholders**
Not applicable since this is a new plan offering.

24. **Proposed Effective Date**
01/01/2014.

**25. Actuarial Certification**

I, Thomas J. Leibowitz, FSA, MAAA, am a member of the American Academy of Actuaries, and meet the Academy Qualification Standard for rendering this Opinion.

I have reviewed the actuarial assumptions and methods on which the rates are based. I hereby certify that to the best of my knowledge and judgment, this rate filing is in compliance with the applicable laws and regulations of the state of Tennessee and complies with Actuarial Standard of Practice No. 8. The rates shown are

- Based on actuarially sound principles
- Are not inadequate, excessive or unfairly discriminatory, and
- Are reasonable in relation to the benefits provided.

Thomas J. Leibowitz, FSA, MAAA
Vice President and Chief Actuary
Dentegra Insurance Company
One First Street
San Francisco, CA 94105

**Attachment A**

**Tennessee Individual Supplemental Dental Benefits**

| PPO/PPO | Pediatric High | Pediatric Low | Adult Preferred | Adult Basic |
|---|---|---|---|---|
| Diagnostic & Preventive | 100% | 100% | 100% | 100% |
| Basic Services | 80% | 50% | 80% | 80% |
| Major Services | 50% | 50% | 50% | 0% |
| Orthodontics (Medically Necessary) | 50% | 50% | NAB* | NAB* |
| Deductible | | | | |
| Waived on D&P | yes | no | yes | yes |
| Per Person | $25 | $45 | $50 | $50 |
| Family | n/a | n/a | $150 | $150 |
| Annual Maximum | None | None | $1,000 | $1,000 |
| Othodontics Maximum (Lifetime) | None | None | NAB* | NAB* |
| Waiting Periods (Major & Ortho) | None | None | 12 mos | None |
| Out of Pocket Maximum (PPO dentists only) | | | | |
| per child | $700 | $700 | NAB* | NAB* |
| per 2+ children | $1,400 | $1,400 | NAB* | NAB* |
| Dental Accident Benefits | NAB* | NAB* | 100% w/ $1000 Lifetime Max | NAB* |
| **Rates:** Statewide | $32.34 | $26.05 | $53.30 | $33.06 |

* NAB is not a benefit

Note: Plan combinations and covered procedures are defined in the forms

**Attachment B**

**Tennessee Individual Administrative Expenses (as a percent of premium)**

| | Pediatric High | Pediatric Low | Adult Preferred | Adult Basic |
|---|---|---|---|---|
| Admin Expenses | 22.50% | 22.50% | 22.50% | 22.50% |
| Risk Margin | 5.50% | 3.00% | 5.50% | 5.50% |
| Premium Tax | 2.50% | 2.50% | 2.50% | 2.50% |
| ACA Tax | 2.00% | 2.00% | 2.00% | 2.00% |
| TPA Admin | 0.00% | 0.00% | 0.00% | 0.00% |
| Commissions | 5.00% | 5.00% | 5.00% | 5.00% |
| Total | 37.50% | 35.00% | 37.50% | 37.50% |
| | | | | |
| Anticipated Loss Ratio ** | 65.45% | 68.06% | 65.45% | 65.45% |

** Anticipated Loss Ratio = (1 - Total) / (1 - Premium Tax - ACA Tax)

**Attachment C**
**DDIC Small Group Experience**

| | **CY2012** |
|---|---|
| Number of Policy Holders | 2,881 |
| Number of Certificate Holders | 38,308 |
| Earned Premium | $24,525,709 |
| Average Annual Premium | $640 |
| Incurred Claims | $16,016,000 |
| Number of Incurred Claims | 124,033 |
| Incurred Loss Ratio | 65.3% |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *DDPA-129064431* | ***State Tracking #:*** | *H-130880* | ***Company Tracking #:*** | *DIC, HCR IND PPO TN, FORMS AND RATES* |

| | | | |
|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *Dentegra Insurance Company* |
| ***TOI/Sub-TOI:*** | *H10I Individual Health - Dental/H10I.000 Health - Dental* | | |
| ***Product Name:*** | *DIC, HCR Ind PPO TN, forms and rates* | | |
| ***Project Name/Number:*** | */* | | |

## Supporting Document Schedules

| | |
|---|---|
| **Bypassed - Item:** | Cover Letter Accident & Health |
| **Bypass Reason:** | Pertinent information is included in the filing description. |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Description of Variables |
| **Comments:** | Statements of variability are attached for review. |
| **Attachment(s):** | PIP-TN-DIC (with Comments 6-5-13).pdf<br>PIAtAhi-TN-DIC (With Comments 6-11-13).pdf<br>PIAtAlo-TN-DIC (with Comments 6-11-13).pdf<br>PIAtB-TN-DIC (with Comments 6-5-13).pdf<br>XIAtAhi-TN-DIC (with Comments 6-11-13).pdf<br>XIAtAlo-TN-DIC (with Comments 6-11-13).pdf<br>XIAtB-TN-DIC (with Comments 6-11-13).pdf<br>XIAtChi-TN-DIC (with Comments 6-11-13)pdf.pdf<br>XIAtClo-TN-DIC (with Comments 6-11-13).pdf<br>XIP-TN-DIC (with Comments 6-11-13).pdf |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | Filing Fees |
| **Bypass Reason:** | We pay associated filing domiciliary fees via EFT. |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Satisfied - Item:** | Readability Certification |
| **Comments:** | Readability Certification is attached for review. |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *DDPA-129064431* | ***State Tracking #:*** | *H-130880* | ***Company Tracking #:*** | *DIC, HCR IND PPO TN, FORMS AND RATES* |

| | | | |
|---|---|---|---|
| ***State:*** | *Tennessee* | ***Filing Company:*** | *Dentegra Insurance Company* |
| ***TOI/Sub-TOI:*** | *H10I Individual Health - Dental/H10I.000 Health - Dental* | | |
| ***Product Name:*** | *DIC, HCR Ind PPO TN, forms and rates* | | |
| ***Project Name/Number:*** | */* | | |

| | |
|---|---|
| **Attachment(s):** | Tennessee Readability Certification.pdf |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | Third Party Authorization |
| **Bypass Reason:** | The insurance company is filing on its own behalf. |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | Actuarial Memorandum A & H Certification - Individual |
| **Bypass Reason:** | The Actuarial Memorandum contains the required certification |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

| | |
|---|---|
| **Bypassed - Item:** | Accident & Health - Individual New Rates |
| **Bypass Reason:** | Actuarial Memorandums are located under the Rate Tab section. |
| **Attachment(s):** | |
| **Item Status:** | |
| **Status Date:** | |

[State logo[D1]]


# Dentegra® Dental PPO

## Children's [Plan 70/Plan 85[D2]]

Combined Policy and Disclosure Form

Provided by:

Dentegra Insurance Company

variable text - highlight & delete if not needed
variable text - highlight & delete if not needed

**This Policy is conditionally renewable and may be terminated if all policies in this state are terminated.**

[dentegra[D3].com]

[State website and phone number[D4]]

# Policy

Your dental plan is underwritten by Dentegra® Insurance Company ("Dentegra") and administered by Delta Dental Insurance Company. Dentegra will pay Benefits for covered dental services as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first installment of Premium. It takes effect on the Effective Date shown on Attachment A Benefits Summary ("Attachment A") attached to this Policy. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where you live.

**READ YOUR POLICY AND ATTACHMENTS CAREFULLY**

**Ten (10)-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY**

Please read this Policy. If this Policy was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements or if you are not satisfied for any reason, you may return the Policy within ten (10) days after its delivery. Mail or deliver it to Dentegra's home office or to the agent through whom you purchased it. Any Premium paid will be refunded. This Policy will then be void from its start.

This Policy is signed for Dentegra, as of its Effective Date by:

Anthony S. Barth, Vice Chairman

## Table of Contents

# INTRODUCTION

We are pleased to welcome you to this individual Dentegra PPO dental plan. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

**NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.**

## Using This Policy

This Policy discloses the terms and conditions of the coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that "you" and "your" mean the Enrollees who are covered under this Policy. "We", "us" and "our" always refer to Dentegra.

## Contact Us

If you have any questions about your coverage that are not answered here, please visit our website at [dentegra[D5].com] or call our Customer Service Center. A Customer Service representative can answer questions you may have about obtaining dental care, help you locate a Dentegra Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at [877[D6]-280-4204] to obtain information about Enrollee Benefits, claim status or to speak to a Customer Service representative for assistance. If you prefer to write to us with your question(s) please mail your inquiry to the following address:

Dentegra Insurance Company
[[SF7]P.O. Box 1850
Alpharetta, GA 30023-1850]

## Identification Number

Please provide the Enrollee's ID number to your Provider whenever you receive dental services. The Enrollee ID number should be included on all claims submitted for payment. Identification cards are not required, but if you wish to have one you may obtain one by visiting our website at [dentegra.com].

## DEFINITIONS

The following are definitions of words that have special or technical meanings under this Policy.

**Accepted Fee:** the amount the attending Provider agrees to accept as payment in full for services rendered.

**Benefits (In-Network or Out-of-Network)**: the amounts that Dentegra will pay for dental services under this Policy. In-Network Benefits are those covered by this Policy and performed by a Dentegra Provider. Out-of-Network Benefits are those covered by this Policy a Non-Dentegra Provider.

**Benefit Year/Calendar Year:** the 12 months of the year from January 1 through December 31.

**Claim Form:** the standard form used to file a claim, request Pre-Treatment Estimate or request Prior Authorization for medically necessary orthodontics.

**Deductible:** a dollar amount that a Pediatric Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits.

**Dentegra PPO℠ Provider (Dentegra Provider):** a Provider who contracts with Dentegra and agrees to accept the Dentegra Provider's Contracted Fees as payment in full for services provided under this PPO plan.

**Dentegra PPO Provider's Contracted Fee (Dentegra Provider's Contracted Fee):** the fee for each Single Procedure that Dentegra Providers have contractually agreed to accept as payment in full for treating Enrollees.

**Effective Date**: The original date the plan starts. This date is given in Attachment A.

**Eligible Pediatric Enrollee**: a person who is considered to be a Qualified Individual by the Tennessee Federally Facilitated Marketplace Exchange and is eligible for Benefits as described in this Policy.

**Exchange**: Tennessee Federally Facilitated Marketplace Exchange.

**Maximum Contract Allowance:** the reimbursement under the Enrollee's benefit plan against which Dentegra calculates its payment and the financial obligation for the Enrollee. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by Dentegra Providers is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee; or
- by a Non-Dentegra Provider is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee for a Dentegra Provider in the same geographic area.

**Non-Dentegra Provider:** a Provider who is not a Dentegra Provider and has not agreed to accept the Dentegra Provider's Contracted Fees.

**Open Enrollment Period:** the period of the year that the Exchange has established when the Responsible Party may change coverage selections for the next Contract Year.

**Out-of-Pocket Maximum:** the maximum amount that a Pediatric Enrollee must satisfy for covered dental services during the Calendar Year provided a Dentegra Provider is used. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Provider even after the Out-of-Pocket Maximum has been met. The Out-of-Pocket Maximum for Dentegra Providers is shown in Attachment A.

**Patient Pays:** the financial obligation for a Pediatric Enrollee for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

**Pediatric Enrollee:** an Eligible Pediatric Enrollee enrolled to receive Benefits; may also be referred to as "Enrollee".

**Policy:** means this agreement between Dentegra and the Responsible Party including any application supplied by Tennessee Federally Facilitated Marketplace Exchange, any attached amendments and appendices. This Policy constitutes the entire agreement between the parties.

**Policy Benefit Level:** the percentage of Maximum Contract Allowance that Dentegra will pay before the Out-of-Pocket Maximum has been satisfied.

**Policy Term:** the period during which this Policy is in effect.

**Policy Year:** the 12 months starting on January 1st and each subsequent 12 month period thereafter coinciding with the Benefit Year. Policy Year can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change.

**Premium:** the amount payable as provided in Attachment A.

**Pre-Treatment Estimate:** an estimation of the allowable Benefits under this Policy for the services proposed, assuming the person is an eligible Enrollee.

**Procedure Code:** the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

**Program Allowance:** the amount determined by a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program allowances may differ based on the Provider's contracting status.

**Provider:** a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

**Qualified Individual:** an individual determined by Tennessee Federally Facilitated Marketplace Exchange to be eligible to enroll through the Exchange.

**Qualifying Status Change:** a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- dependent child ceases to satisfy eligibility requirements;
- a court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by the Exchange.

**Responsible Party**: the person who enrolls an Eligible Pediatric Enrollee for Benefits.

**Single Procedure**: a dental procedure that is assigned a separate Procedure Code.

**Spouse**: a person related to or a partner of the Responsible Party:

- as defined and as may be required to be treated as a Spouse by the laws of the state where this Policy is issued and delivered; or
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Responsible Party resides.

**Submitted Fee:** the amount that the Provider bills and enters on a claim for a specific procedure.

# ELIGIBILITY AND ENROLLMENT

## Eligibility Requirement

Eligible Pediatric Enrollees are Qualified Individuals as determined by the Exchange. A Qualified Individual must satisfy the Exchange's requirements regarding:

- Citizenship, status as a national, or otherwise lawfully present in the United States;
- Incarceration;
- Residency.

Eligible Pediatric Enrollees can be:

Responsible Party's dependent children from birth to age 26 and include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of Spouse. Adopted children are eligible from the date of entry into the adoptive home or filing of the petition for adoption, whichever occurs first. If the child is in the custody of the state, coverage will begin at the date of entry of a final decree of adoption. Coverage for an adopted child will continue unless the petition is denied.

## Enrollment Grace Period

There is a period of 10 days from the Pediatric Enrollee's coverage Effective Date during which the Responsible Party may rescind this Policy and receive a full refund, provided the Pediatric Enrollee has not used Benefits under this Policy.

## RENEWABLE - PREMIUM MAY CHANGE CONDITIONALLY:

The rate of the monthly Premiums will not be increased during the initial Policy Year.

The Responsible Party will receive renewal information from the Exchange prior to any applicable open enrollment period. Provided Dentegra continues to make this policy available through the Exchange at the renewal period:

- the Responsible Party may elect to choose this Contract on behalf of Eligible Pediatric Enrollees, subject to the applicable Premium through the Exchange for this plan at the time of renewal; and

- The Responsible Party may not have to make an election through the Exchange in subsequent open enrollment periods to continue coverage for Eligible Pediatric Enrollees. The Responsible Party should refer to the Exchange rules regarding automatic renewal of coverage.

## Termination of Coverage

The Enrollee and/or Responsible Party have the right to terminate coverage under this Policy by sending Dentegra or the Exchange written notice of intent to terminate this Policy. The effective date of a requested termination will be fourteen days from the date of Dentegra's receipt of the request for termination. If coverage is termed because the Pediatric Enrollee is covered by Medicaid, the last day of coverage with Dentegra is the day before the new coverage is effective.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date.

The Responsible Party may keep this Policy in force by timely payment of the Premiums. However, Dentegra may terminate coverage due to:

- Enrollee no longer eligible through the Exchange;
  - if termination is due to loss of eligibility through the Exchange, termination is effective the last day of the month following the month that the Exchange notifies you of lack of eligibility;
- non-payment of Premium:
  - if Premiums are not received by the 90th day of the Premium grace period, your policy will be terminated as of the 31st day of the Premium grace period. See *Grace Period on Late Payments*.
- Fraud or material misrepresentation made by or with the knowledge of the Responsible Party or the Enrollee applying for this coverage or filing a claim for benefits;
- Enrollee has reached the age of 26;
- the Responsible Party changes to a new pediatric dental policy for Enrollees through Tennessee Federally Facilitated Marketplace Exchange; or
- Dentegra ceasing to renew all Policies issued on this form to residents of the state where you live.

## Reinstatement

If you do not pay the Premium within the time granted for payment, the Policy will be terminated as of the 31st day of the Premium grace period. See *Grace Period on Late Payments*.

If the Policy is terminated you may re-enroll in the program at the next Open Enrollment Period and the deductible and maximum applicable to your program will start over. However, the Policy may be reinstated with no break in coverage provided the full Premium due is received by us within 90 days of the date of the past due Premium. The reinstated Policy will have the same rights as before your Policy lapsed, unless a change is made to the Policy in connection with the reinstatement. These changes, if any, will be sent to you for you to attach to the Policy.

# OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how this dental plan works and how to make it work best for you.

## Benefits, Limitations and Exclusions

We will pay Benefits for the types of dental services as described in Attachment B Services, Limitations and Exclusions ("Attachment B") and Attachment B-1 Schedule of Covered Services and Limitations ("Attachment B-1").

We will pay Benefits only for covered services. This Policy covers several categories of Benefits when a Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims shall be processed in accordance with our standard processing policies. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under this Policy. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

## Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown in the Attachment A, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled "Selecting Your Provider"). Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select Dentegra Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the sections titled "Selecting Your Provider" for more information.

## Deductible

A deductible ("Deductible") is an amount the Responsible Party must pay out-of-pocket before Benefits are paid. The Deductible amounts, if any, are listed in Attachment A. Deductibles apply to all covered dental services unless otherwise noted. Only the Provider's fees paid for covered Benefits will count toward the Deductible.

## Prior Authorization for Medically Necessary Orthodontics

Orthodontic treatment is covered only when medically necessary as evidenced by a severe handicapping malocclusion, and prior authorization ("Prior Authorization") is required. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

## Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under this Policy for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before the Pediatric Enrollee receives any prescribed treatment, you will have an estimate up front of what we will pay and the difference is the financial obligation of the Responsible Party. The Benefits will be processed according to the terms of this Policy when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

1) the date this Policy terminates;
2) the date the Enrollee's coverage ends; or
3) the date the Provider's agreement with Dentegra ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are covered and meet all the requirements of the plan at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

# SELECTING YOUR PROVIDER

## Free Choice of Provider

We recognize that many factors affect the choice of Provider and therefore support your right to freedom of choice regarding your Provider. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may

see any Provider for your covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider.

**Remember, you enjoy the greatest benefits—including out-of-pocket savings—when you choose a Dentegra Provider.** To take full advantage of your Benefits, we highly recommend you verify a dentist's participation status with Dentegra with your dental office before each appointment. Review this section for an explanation of Dentegra payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

## Locating a Dentegra Provider

You may access information through our website at dentegra.com. You may also call our Customer Service Center and one of our representatives will assist you. We can provide you with information regarding a Provider's network, specialty and office location.

## Choosing a Dentegra Provider

Selecting a Dentegra Provider potentially allows the greatest reduction in Pediatric Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon. Also, the services received from a Dentegra Provider apply towards the Out-of-Pocket Maximum limiting a Pediatric Enrollee's out-of-pocket costs to the amount shown in Attachment A.

## Choosing a Non-Dentegra Provider

If a Provider is a Non-Dentegra Provider, the amount charged may be above that accepted by the Dentegra Providers, and Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply after the Out-of-Pocket Maximum is met. Costs incurred with a Non-Dentegra Provider do not count towards the Out-of-Pocket maximum. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

## Additional Obligations of Dentegra Providers:

- The Dentegra Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Dentegra after satisfaction of the Deductible and Coinsurance, and the Pediatric Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.

- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra PPO Provider's Contracted Fees.

## How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form, which most dental offices have available. Dentegra Providers will fill out and submit your claims paperwork for you. Some Non-Dentegra Providers may also provide this service upon your request. If you receive services from a Non-Dentegra Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Claim Form" for more information.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Dentegra Insurance Company

[P.O. Box 1850

Alpharetta, GA 30023-1850]

## Payment Guidelines

We do not pay Dentegra Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider files a claim for services more than 15 months after the date you received the services, payment may be denied. If the services were received from a Non-Dentegra Provider, you are still responsible for the full cost. If the payment is denied because your Dentegra Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your Dentegra Provider that you were covered under a Dentegra Policy at the time you received the service, you may be responsible for the cost of that service.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, please contact us.

# PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment, and any subsidy you receive, if applicable. Premiums are listed on Attachment A. An Eligible Enrollee is responsible for making Premium payments, paying Deductibles and Coinsurance and ensuring the Provider is aware of any other dental coverage he/she carries. Each Premium is to be paid on or before its due date. A due date is the day following the last day of the period for which the preceding Premium was paid.

You may pay your Premium by visiting our website at dentegra.com, or by mailing payment to the address below:

Dentegra Insurance Company

[P.O. Box 660138

Dallas, TX 75266-0138]

## Rate Guarantee

Your initial Premium rate is guaranteed for the first 12 months of your Policy, based upon the new enrollee rates in force at the time of your enrollment. The rate guarantee can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change.

No change in Premiums shall become effective within a Policy Term, unless Dentegra's liability is changed by law or regulation. Such a change may include a state and/or federal mandated change or a new or increased tax, assessment or fee imposed on the amounts payable to, or by, Dentegra under this Policy or any immediately preceding Policy between Company and you. Company would provide written notice to you, and this Policy shall thereby be modified on the date set forth in the notice.

## Changing Payment Options

Payment options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on your new billing period. You can change your payment option [by[D8] visiting our website at [dentegra.com] or] by contacting our Customer Service department toll-free at [877-280-4204].

## Grace Period on Late Payments

If your Premium payment is not received by the first of the month, a grace period of 90 days will be granted. During the first 31 days of the grace period, the Policy shall continue in force. If premiums are not received by the 31st day of the grace period, claims will be placed on hold until the 90th day of the grace period. If premiums are not received by the 90th day of the grace period, your policy will be terminated as of the 31st day of the grace period.

# GRIEVANCES AND APPEALS

If you have questions about any services received, we recommend that you first discuss the matter with your Provider. However, if you continue to have concerns, please call our Customer Service Center. You can also e-mail questions by accessing the "Contact Us" section of our website at [dentegra.com].

Grievances regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Dentegra, or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at [877-280-4204].

When you write, please include the name of the Pediatric Enrollee, the ID number, and your telephone number on all correspondence. You should also include a copy of the Claim Form, claim statement, or other relevant information. Your claim statement will have an explanation of the claim review and any grievance process and time limits applicable to such process.

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, based upon lack of medical necessity. Any such denial will be based upon a determination by a Provider who holds a non-restricted license in the same or an appropriate specialty that typically manages the dental condition, procedure, or treatment under review. You and your Provider have at least 180 days after receiving a notice of denial to request a review by writing to Dentegra giving reasons why you believe the denial was wrong. You may also ask Dentegra to examine any additional information you include that may support your grievance.

Send your grievance to us at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

We will send you a written acknowledgment within 5 days upon receipt of your grievance. We will make a full and fair review within 30 days after we receive the grievance. We may ask for more documents if needed. We will send you a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Policy, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

## Appeals

If you believe you need further review of your claim and/or your grievance, you may contact your state insurance regulatory agency.

# PROVISIONS REQUIRED BY LAW

## Entire Contract; Changes

This Policy, including the endorsements and the attached papers, constitutes the entire contract of insurance. No change to this Policy shall be valid until approved by our executive officer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

## Incontestability

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by you in the application for this Policy will be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 3-year period.

No claim for loss incurred or disability commencing after three (3) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss has existed prior to the Effective Date of this Policy.

## Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us when and as often as it may reasonably require during the pendency of a claim, in or near your community or residence. We will in every case hold such information and records confidential.

## Written Notice of Claim / Proof of Loss

We must be given written proof of loss within 15 months after the date of the loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required, provided that the proof is filed as soon as reasonably possible. A notice of claim submitted by you, on your behalf, or on behalf of your beneficiary to us or to our authorized agent, with information sufficient to identify you will be considered notice of claim.

All written proof of loss must be given to us within 12 months of the termination of this Policy.

Send your Notice of Claim/Proof of Loss to us at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

## Claim Form

We will, within 20 days after receiving a notice of a claim, provide you or your Provider with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If we do not send you or your Provider a Claim Form within 15 days after you or your Provider gave us notice regarding a claim, the requirements for proof of loss outlined in the section "Written Notice of Claim/Proof of Loss" above will be deemed to have been complied with as long as you give us written proof that explains the type and the extent of the loss that you are making a claim for within the time established for filing proofs of loss. You may download a Claim Form from our website.

## Time of Payment

Claims payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be processed immediately after written proof of loss is received in the form required by the terms of this Policy. We will notify you and your Provider of any additional information needed to process the claim.

## To Whom Benefits Are Paid

It is not required that the service be provided by a specific dentist. Payment for services provided by a Dentegra Provider will be made directly to the dentist. Any other payments provided by the Policy will be made to you, unless you request when filing a proof of claim that the payment be made directly to the dentist providing the services. All benefits not paid to the Provider will be payable to you or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

## Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by you will be deemed

representations and not warranties. No such statement will be used in defense to a claim under this Policy, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the Policy at the same Premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the Premium to reflect your actual circumstances at time of application or to terminate your policy.

## Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Policy, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by this Policy.

## Conformity with State Laws

All legal questions about this Policy will be governed by the state of Tennessee where this Policy was entered into and is to be performed. Any part of this Policy which conflicts with the laws of Tennessee or federal law is hereby amended to conform to the minimum requirements of such laws.

## Third Party Administrator (“TPA”)

Dentegra may use the services of a TPA, duly registered under applicable state law, to provide services under this Contract. Any TPA providing such services or receiving such information will enter into a separate Business Associate Agreement with Dentegra providing that the TPA shall meet HIPAA and HITECH requirements of the preservation of protected health information of Pediatric Enrollees.

# NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice is required by law to tell you how Dentegra protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Dentegra receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Dentegra program, and we will notify you of how you can receive a copy of this notice every three years.

## Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Dentegra in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate. These affiliates have also implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

**Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations**

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.
  *For example, Dentegra may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment.
  *For example, Dentegra may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations.
  *For example, Dentegra may use and disclose your PHI to review the quality of care provided by our network of providers.*

**Disclosures Without an Authorization**

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Dentegra may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

**Disclosures Dentegra Makes With Your Authorization**

Dentegra will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Dentegra or by a person requesting your PHI from Dentegra.

**Your Rights Regarding PHI**

**You have the right to request an inspection of and obtain a copy of your PHI.** You may access your PHI by contacting the appropriate Dentegra office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Dentegra may charge a reasonable fee for providing you copies of your PHI. Dentegra will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Dentegra to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Dentegra does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

**You have the right to request a restriction of your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

**You have the right to correct or update your PHI.** This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

**You have the right to request or receive confidential communications from us by alternative means or at a different address.** We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

**You have the right to get this notice by email.** You have the right to get a copy of this notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice.

**Complaints**

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Dentegra has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

**Contact**

You may contact the privacy office at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Dentegra Insurance Company
c/o Office of Compliance
[P.O. Box 1850
Alpharetta, GA 30023-1850]

Phone: [877-280-4204]

**This notice is effective on and after August 1, 2012.**

# EMPLOYEE NOTICE

# NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

## COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
(2) the insurer was not authorized to do business in this state;
(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) any policy of reinsurance (unless an assumption certificate was issued);
(3) interest rate yields that exceed an average rate;
(4) dividends;
(5) credits given in connection with the administration of a policy by a group contract holder;
(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
(7) unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

## LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**Tennessee Life and Health Insurance Guaranty Association 150 3rd Avenue South, Suite 1600 Nashville, TN 37201**

**Tennessee Department of Commerce and Insurance 500 James Robertson Parkway Nashville,Tennessee 37243**

## Main document changes and comments

**Page i: Comment [D1]** **Courtney Rozear (ga24413)** **6/6/2013 3:17:00 PM**

State logo will be inserted here if required.

**Page i: Comment [D2]** **Courtney Rozear (ga24413)** **6/6/2013 3:17:00 PM**

This field will be updated with the plan name to be issued.

**Page i: Comment [D3]** **Courtney Rozear (ga24413)** **6/6/2013 3:17:00 PM**

The website address is filed as variable in case in needs to be updated in the future.

**Page i: Comment [D4]** **Courtney Rozear (ga24413)** **6/6/2013 3:18:00 PM**

This information is filed as variable.

**Page 1: Comment [D5]** **Courtney Rozear (ga24413)** **6/6/2013 3:17:00 PM**

The company's website is shown as variable throughout this document should it need to be updated in the future.

**Page 1: Comment [D6]** **Courtney Rozear (ga24413)** **6/6/2013 3:17:00 PM**

The company's phone number is shown as variable throughout this document should it need to be updated in the future.

**Page 1: Comment [SF7]** **Sharon Ford (ga31755)** **6/6/2013 3:17:00 PM**

The company's address is shown as variable throughout this document should it need to be updated in the future.

**Page 11: Comment [D8]** **Courtney Rozear (ga24413)** **6/6/2013 3:17:00 PM**

Dentegra will include payment via its website when available. It is Dentegra's intent to have this capability available by January 2014.

## Header and footer changes

## Text Box changes

## Header and footer text box changes

## Footnote changes

## Endnote changes

# Attachment A
# Benefit Summary
# Dentegra Dental PPO
# Children's Plan 85

**Responsible Party: [Name]**

**Effective Date: [XXXXX]**

**Policy ID Number: [XXXX]**

**Premium:** [Per[D1] Pediatric Enrollee:] [$ X[D2]XXX]

***Premiums are to be remitted [monthly][D3] to:***
**Dentegra Insurance Company**
[Street[D4] PO Box 660138
Dallas, TX 75266-0138]

You have a Calendar Year plan and Deductibles and Out-of-Pocket maximums will be based upon a Calendar Year. If you enroll mid-year due to a Qualifying Status Change, your Policy Year will be shorter than 12 months and will begin again on January 1.

**Annual Deductible**
$25 per Pediatric Enrollee each Calendar Year
The annual Deductible will be waived for Diagnostic and Preventive Services.

**Annual Out-of-Pocket Maximum for Dentegra PPO℠ Providers***
Individual $700 each Calendar Year
Multiple Child $1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount that a Pediatric Enrollee must satisfy for covered services under the Policy during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

If a Responsible Party covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from Dentegra PPO Providers.

| **Policy Benefit Levels** | | |
|---|---|---|
| **Dental Service Category** | **Dentegra PPO Providers†** | **Non-Dentegra Providers†** |
| Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for the following services: | | |
| **Diagnostic and Preventive Services** | 100% | 100% |
| **Basic Services** | 80% | 80% |
| **Major Services** | 50% | 50% |
| **Medically Necessary Orthodontic Services (requires Prior Authorization)** | 50% | 50% |

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

# Variable Form with Comments 6-11-13

**PIAtAhi-TN-DIC (Clean 6-11-13).docx**

## Main document changes and comments

**Page 1: Comment [D1]** **Courtney Rozear (ga24413)** **3/29/2013 3:10:00 PM**

Rate tier variable to be completed when issued.

**Page 1: Comment [D2]** **Courtney Rozear (ga24413)** **3/29/2013 3:10:00 PM**

Premium amount to be completed when issued.

**Page 1: Comment [D3]** **Eboni Warren (ga28462)** **5/21/2013 10:36:00 PM**

To be updated with frequency chosen by Exchange upon notification or when policy issued. If Exchange does not specify a frequency, it will be updated with frequency chosen by Dentegra.

**Page 1: Comment [D4]** **Courtney Rozear (ga24413)** **6/11/2013 9:29:00 AM**

The company's address is shown as variable in case it should need to be updated in the future.

## Header and footer changes

## Text Box changes

## Header and footer text box changes

## Footnote changes

## Endnote changes

# Attachment A
# Benefit Summary
# Dentegra Dental PPO
# Children's Plan 70

**Responsible Party: [Name]**

**Effective Date: [XXXXX]**

**Policy ID Number: [XXXX]**

**Premium:** [Per[D1] Pediatric Enrollee:] [$ X[D2]XXX]

***Premiums are to be remitted [monthly][D3] to:***
**Dentegra Insurance Company**
[Street[D4] PO Box 660138
Dallas, TX 75266-0138]

You have a Calendar Year plan and Deductibles and Out-of-Pocket maximums will be based upon a Calendar Year. If you enroll mid-year due to a Qualifying Status Change, your Policy Year will be shorter than 12 months and will begin again on January 1.

**Annual Deductible**
$45 per Pediatric Enrollee each Calendar Year

**Annual Out-of-Pocket Maximum for Dentegra PPO℠ Providers***
Individual $700 each Calendar Year
Multiple Child $1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount that a Pediatric Enrollee must satisfy for covered services under the Policy during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If a Responsible Party covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from Dentegra PPO Providers.

| **Policy Benefit Levels** | | |
|---|---|---|
| **Dental Service Category** | **Dentegra PPO Providers†** | **Non-Dentegra Providers†** |
| Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for the following services: | | |
| **Diagnostic and Preventive Services** | 100% | 100% |
| **Basic Services** | 50% | 50% |
| **Major Services** | 50% | 50% |
| **Medically Necessary Orthodontic Services (requires Prior Authorization)** | 50% | 50% |

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

# Variable Form with Comments 6-11-13

**PIAtAlo-TN-DIC.docx**

## Main document changes and comments

**Page 1: Comment [D1]** **Courtney Rozear (ga24413)** **3/29/2013 3:10:00 PM**

Rate tier variable to be completed when issued.

**Page 1: Comment [D2]** **Courtney Rozear (ga24413)** **3/29/2013 3:10:00 PM**

Premium amount to be completed when issued.

**Page 1: Comment [D3]** **Eboni Warren (ga28462)** **5/21/2013 10:35:00 PM**

To be updated with frequency chosen by Exchange upon notification or when policy issued. If Exchange does not specify a frequency, it will be updated with frequency chosen by Dentegra.

**Page 1: Comment [D4]** **Courtney Rozear (ga24413)** **6/11/2013 9:23:00 AM**

The company's address is shown as variable in case it should need to be updated in the future.

## Header and footer changes

## Text Box changes

## Header and footer text box changes

## Footnote changes

## Endnote changes

# Attachment B
# Services, Limitations and Exclusions
# Dentegra Dental PPO
# Children's Plan [85/70][D1]

***Description of Dental Services***

Dentegra will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for the services shown on Attachment B-1 when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthodontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a Prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

***Limitations***

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

(3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(4) Dentegra will pay for oral examinations (except exams for observation) no more than twice in a Calendar Year. Only one (1) comprehensive evaluation is allowed in a Calendar Year and counts toward the oral examination frequency in the year provided. One (1) limited oral evaluation, problem-focused no more than once in a Calendar Year.

(5) X-ray limitations:
- a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
- b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
- c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
- d) A complete intraoral series and panoramic film are each limited to once every 60 months.
- e) Bitewing x-rays are limited to two (2) times in a Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(6) Dentegra will pay for routine cleanings and topical application of fluoride solutions no more than twice in a Calendar Year, and periodontal cleanings in the presence of inflamed gums up to four (4) times in a Calendar Year. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings not to exceed four (4) procedures or any combination thereof in a Calendar Year. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic

and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

(7) Space maintainer limitations:
a) Space maintainers are limited to the initial appliance.
b) Recementation of space maintainer is limited to once per lifetime.
c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(8) Sealants are limited as follows:
a) to permanent molars through age 18 if they are without caries (decay) or restorations on the occlusal surface.
b) do not include repair or replacement of a Sealant on any tooth within 36 months of its application.

(9) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.

(10) Dentegra will not cover to replace an amalgam or resin-based composite within 24 months of treatment if the service is provided by the same Provider/Provider office. Pefabricated stainless steel crowns are limited to once per Enrollee per tooth per lifetime. Replacement restorations within 24 months are included in the fee for the original restoration.

(11) Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 15.

(12) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only. It is a benefit for primary incisor teeth up to age six (6) and for primary molars and cuspids to age 11.

(13) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(14) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

(15) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(16) Retrograde fillings per root are limited to once in any 24-month period.

(17) Pin retention is covered not more than once in any 24-month period.

(18) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(19) Periodontal limitations:
a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.
b) Periodontal surgery in the same quadrant is limited to once in every 24-month period and includes any surgical re-entry or scaling and root planing.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
d) If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
f) One crown lengthening per tooth per lifetime.

(20) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(21) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Dentegra determines the existing Crown

or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(22) When an alternate Benefit of an amalgam is allowed for inlays/ onlays, they are limited to Enrollees age 12 and older and are covered not more than once in any 60 month period.

(23) Core buildup, including any pins, are covered not more than once in any 60 month period.

(24) Post and core services are covered not more than once in any 60 month year period.

(25) Crown repairs are covered not more than once in any 60 month period.

(26) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(27) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(28) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Dentegra program will be replaced only after 60 months have passed, except when Dentegra determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Removable cast base partial dentures are limited to Enrollees age 12 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if Dentegra determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.

(29) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(30) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a (6) month period by the same Provider/Provider office.

(31) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Dentegra plan or Enrollee's prior plan, if applicable

(32) Dentegra limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.

a) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments and relining are limited to one (1) per arch in a 36-month period.
c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
d) Recementation of fixed partial dentures is limited to once in a lifetime.

(33) Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period.

(34) Athletic mouth guards are limited to one (1) per 12 consecutive month period.

(35) Internal bleaching of discolored teeth shall not be provided for any tooth more than once each 36 months while the patient is an Enrollee under any Dentegra plan.

***Exclusions***
**Dentegra does not pay Benefits for:**

(1) services not included on Attachment B-1 Schedule of Covered Services except medically necessary Orthodontics provided a Prior Authorization is obtained.

(2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) cosmetic surgery or procedures for purely cosmetic reasons.

(4) maxillofacial prosthetics.

(5) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under).

(6) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

(7) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.

(8) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(9) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(10) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures if such procedures included in Attachment B-1.

(11) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(12) laboratory processed crowns for Enrollees under age 12.

(13) fixed bridges and removable partials for Enrollees under age 16.

(14) indirectly fabricated resin-based Inlays/Onlays.

(15) overdentures.

(16) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(17) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(18) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(19) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(20) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(21) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.

(22) Deductibles and/or any service not covered under the dental plan.

(23) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(24) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Policy or was covered under any dental care plan with Dentegra or the Enrollee's prior dental plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(25) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(26) endodontic endosseous implant.

**PIAtB-TN-DIC (Clean 6-5-13).docx**

## Main document changes and comments

**Page 1: Comment [D1]** **Eboni Warren (ga28462)** **4/23/2013 2:20:00 PM**

Insert the applicable plan number at time of issue.

## Header and footer changes

## Text Box changes

## Header and footer text box changes

## Footnote changes

## Endnote changes

# Attachment A
# Deductibles, Maximums and Policy Benefit Levels for Pediatric Benefits
# Dentegra Dental PPO
# Children's Plan 85

**Primary Enrollee: [Name]**

**Effective Date: [XXXXX]**

**Policy ID Number: [XXXX]**

**Premium:** [Per[D1] Pediatric Enrollee:] [$ X[D2]XXX]

***Premiums are to be remitted [monthly][D3] to:***
**Dentegra Insurance Company**
[Street[D4] PO Box 660138
Dallas, TX 75266-0138]

You have a Calendar Year plan and Deductibles and Out-of-Pocket maximums will be based upon a Calendar Year. If you enroll mid-year due to a Qualifying Status Change, your Policy Year will be shorter than 12 months and will begin again on January 1.

**Annual Deductible**
$25 per Pediatric Enrollee each Calendar Year
The annual Deductible will be waived for Diagnostic and Preventive Services.

**Annual Out-of-Pocket Maximum for Dentegra PPO Providers***
Individual $700 each Calendar Year
Multiple Child $1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount that a Pediatric Enrollee must satisfy for covered services under the Policy during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If a Primary Enrollee covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services provided by Dentegra PPO Providers.

| **Policy Benefit Levels** | | |
|---|---|---|
| **Dental Service Category** | **Dentegra PPO Providers†** | **Non-Dentegra Providers†** |
| Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for the following services: | | |
| **Diagnostic and Preventive Services** | 100% | 100% |
| **Basic Services** | 80% | 80% |
| **Major Services** | 50% | 50% |
| **Medically Necessary Orthodontic Services (requires Prior Authorization)** | 50% | 50% |

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

# Variable Form with Comments 6-10-13

**XIAtAhi-TN-DIC (Clean 6-11-13).docx**

## Main document changes and comments

**Page 1: Comment [D1]** **Courtney Rozear (ga24413)** **3/29/2013 3:10:00 PM**

Rate tier variable to be completed when issued.

**Page 1: Comment [D2]** **Courtney Rozear (ga24413)** **3/29/2013 3:10:00 PM**

Premium amount to be completed when issued.

**Page 1: Comment [D3]** **Eboni Warren (ga28462)** **6/11/2013 11:01:00 AM**

To be updated with frequency chosen by Exchange upon notification or when policy issued. If Exchange does not specify a frequency, it will be updated with frequency chosen by Dentegra.

**Page 1: Comment [D4]** **Courtney Rozear (ga24413)** **6/11/2013 10:59:00 AM**

The company's address is shown as variable in case it should need to be updated in the future.

## Header and footer changes

## Text Box changes

## Header and footer text box changes

## Footnote changes

## Endnote changes

# Attachment A
## Deductibles, Maximums and Policy Benefit Levels for Pediatric Benefits
## Dentegra Dental PPO
## Children's Plan 70

**Primary Enrollee: [Name]**

**Effective Date: [XXXXX]**

**Policy ID Number: [XXXX]**

**Premium:** [Per[D1] Pediatric Enrollee:] [$ X[D2]XXX]

***Premiums are to be remitted [monthly][D3] to:***
**Dentegra Insurance Company**
[Street[D4] PO Box 660138
Dallas, TX 75266-0138]

You have a Calendar Year plan and Deductibles and Out-of-Pocket maximums will be based upon a Calendar Year. If you enroll mid-year due to a Qualifying Status Change, your Policy Year will be shorter than 12 months and will begin again on January 1.

**Annual Deductible**
$45 per Pediatric Enrollee each Calendar Year

**Annual Out-of-Pocket Maximum for Dentegra PPO Providers***
Individual $700 each Calendar Year
Multiple Child $1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount that a Pediatric Enrollee must satisfy for covered services under the Policy during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If a Primary Enrollee covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services provided by Dentegra PPO Providers.

| **Policy Benefit Levels** | | |
|---|---|---|
| **Dental Service Category** | **Dentegra PPO Providers†** | **Non-Dentegra Providers†** |
| Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for the following services: | | |
| **Diagnostic and Preventive Services** | 100% | 100% |
| **Basic Services** | 50% | 50% |
| **Major Services** | 50% | 50% |
| **Medically Necessary Orthodontic Services (requires Prior Authorization)** | 50% | 50% |

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

# Variable Form with Comments 6-10-13

**XIAtAlo-TN-DIC (Clean 6-11-13).docx**

## Main document changes and comments

**Page 1: Comment [D1]** **Courtney Rozear (ga24413)** **3/29/2013 3:10:00 PM**

Rate tier variable to be completed when issued.

**Page 1: Comment [D2]** **Courtney Rozear (ga24413)** **3/29/2013 3:10:00 PM**

Premium amount to be completed when issued.

**Page 1: Comment [D3]** **Eboni Warren (ga28462)** **5/16/2013 4:22:00 PM**

To be updated with frequency chosen by Exchange upon notification or when policy issued. If Exchange does not specify a frequency, it will be updated with frequency chosen by Dentegra.

**Page 1: Comment [D4]** **Courtney Rozear (ga24413)** **6/11/2013 11:06:00 AM**

The company's address is shown as variable in case it should need to be updated in the future.

## Header and footer changes

## Text Box changes

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## Footnote changes

## Endnote changes

# Attachment B
# Services, Limitations and Exclusions for Pediatric Benefits
# Dentegra PPO
# Children's Plan [85/70[D1]]

## *Description of Dental Services*

Dentegra will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for the services shown on Attachment B-1 when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthdontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a Prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

## *Limitations*

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

(3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(4) Dentegra will pay for oral examinations (except exams for observation) no more than twice in a Calendar Year. Only one (1) comprehensive evaluation is allowed in a Calendar Year and counts toward the oral examination frequency in the year provided. One (1) limited oral evaluation, problem-focused no more than once in a Calendar Year.

(5) X-ray limitations:
- a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
- b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
- c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
- d) A complete intraoral series and panoramic film are each limited to once every 60 months.
- e) Bitewing x-rays are limited to two (2) times in a Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(6) Dentegra will pay for routine cleanings and topical application of fluoride solutions no more than twice in a Calendar Year, and periodontal cleanings in the presence of inflamed gums up to four (4) times in a Calendar Year. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings not to exceed four (4) procedures or any combination thereof in a Calendar Year. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

(7) Space maintainer limitations:
- a) Space maintainers are limited to the initial appliance.
- b) Recementation of space maintainer is limited to once per lifetime.

c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(8) Sealants are limited as follows:
a) to permanent molars through age 18 if they are without caries (decay) or restorations on the occlusal surface.
b) do not include repair or replacement of a Sealant on any tooth within 36 months of its application.

(9) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.

(10) Dentegra will not cover to replace an amalgam or resin-based composite within 24 months of treatment if the service is provided by the same Provider/Provider office. Pefabricated stainless steel crowns are limited to once per Enrollee per tooth per lifetime. Replacement restorations within 24 months are included in the fee for the original restoration.

(11) Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 15.

(12) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only. It is a benefit for primary incisor teeth up to age six (6) and for primary molars and cuspids to age 11.

(13) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(14) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

(15) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(16) Retrograde fillings per root are limited to once in any 24-month period.

(17) Pin retention is covered not more than once in any 24-month period.

(18) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(19) Periodontal limitations:
a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.
b) Periodontal surgery in the same quadrant is limited to once in every 24-month period and includes any surgical re-entry or scaling and root planing.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
d) If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
f) One crown lengthening per tooth per lifetime.

(20) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(21) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Dentegra determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(22) When an alternate Benefit of an amalgam is allowed for inlays/ onlays, they are limited to Enrollees age 12 and older and are covered not more than once in any 60 month period.

(23) Core buildup, including any pins, are covered not more than once in any 60 month period.

(24) Post and core services are covered not more than once in any 60 month year period.

(25) Crown repairs are covered not more than once in any 60 month period.

(26) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(27) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(28) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Dentegra program will be replaced only after 60 months have passed, except when Dentegra determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Removable cast base partial dentures are limited to Enrollees age 12 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if Dentegra determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.

(29) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(30) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a (6) month period by the same Provider/Provider office.

(31) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Dentegra plan or Enrollee's prior plan, if applicable

(32) Dentegra limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
   a) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
   b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments and relining are limited to one (1) per arch in a 36-month period.
   c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
   d) Recementation of fixed partial dentures is limited to once in a lifetime.

(33) Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period.

(34) Athletic mouth guards are limited to one (1) per 12 consecutive month period.

(35) Internal bleaching of discolored teeth shall not be provided for any tooth more than once each 36 months while the patient is an Enrollee under any Dentegra plan.

### *Exclusions*

**Dentegra does not pay Benefits for:**

(1) services not included on Attachment B-1 Schedule of Covered Services except medically necessary Orthodontics provided a Prior Authorization is obtained.

(2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) cosmetic surgery or procedures for purely cosmetic reasons.

(4) maxillofacial prosthetics.

(5) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under).

(6) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

(7) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.

(8) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(9) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(10) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures if such procedures included in Attachment B-1.

(11) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(12) laboratory processed crowns for Enrollees under age 12.

(13) fixed bridges and removable partials for Enrollees under age 16.

(14) indirectly fabricated resin-based Inlays/Onlays.

(15) overdentures.

(16) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(17) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(18) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(19) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(20) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(21) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.

(22) Deductibles and/or any service not covered under the dental plan.

(23) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(24) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Policy or was covered under any dental care plan with Dentegra or the Enrollee's prior dental plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(25) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(26) endodontic endosseous implant.

**XIAtB-TN-DIC (Clean 6-11-13).docx**

## Main document changes and comments

**Page 1: Comment [D1]** **Eboni Warren (ga28462)** **4/23/2013 2:21:00 PM**

Insert the applicable plan number at time of issue.

## Header and footer changes

## Text Box changes

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## Footnote changes

## Endnote changes

# Attachment C
# Deductibles, Maximums and Policy Benefit Levels for Adult Benefits
# Dentegra Dental PPO
# Adult Preferred

**Primary Enrollee: [Name]**

**Effective Date: [XXXXX]**

**Policy ID Number: [XXXX]**

**Premium:** [Per[D1] Enrollee:] [$ X[D2]XXX]

***Premiums are to be remitted [monthly]***[D3] ***to:***
Dentegra Insurance Company
[Street[D4] PO Box 660138
Dallas, TX 75266-0138]

You have a Calendar Year plan and Deductibles and Maximums will be based upon a Calendar Year. If you enroll mid-year due to a Qualifying Status Change, your Policy Year will be shorter than 12 months and will begin again on January 1.

| Deductibles & Maximums | |
|---|---|
| **Annual Deductible** | $50 per Enrollee each Calendar Year<br>$150 per family each Calendar Year |
| Deductibles waived for | Diagnostic & Preventive |
| **Annual Maximum** | $1,000 per Enrollee per Calendar Year |
| **Dental Accident Maximum** | $1,000 per Enrollee per lifetime |

| Policy Benefit Levels | | |
|---|---|---|
| **Dental Service Category** | **Dentegra PPO Provider**† | **Non-Dentegra Providers**† |
| Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for the following services: | | |
| **Diagnostic & Preventive** | 100% | 100% |
| **Basic Restorative** | 80% | 80% |
| **Major Services** | 50% | 50% |
| **Dental Accident** | 100% | 100% |

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

## Waiting Periods:

- Major Services are limited to Enrollees who have been enrolled in the Policy for 12 consecutive months. Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date of Coverage reported by the Exchange for said Primary Enrollee and/or Dependent Enrollee.

# Variable Form with Comments 6-10-13

**XIAtChi-TN-DIC (Clean 6-11-13).docx**

## Main document changes and comments

**Page 1: Comment [D1]** **Courtney Rozear (ga24413)** **4/11/2013 4:20:00 PM**

Rate tier variable to be completed when issued.

**Page 1: Comment [D2]** **Courtney Rozear (ga24413)** **4/11/2013 4:20:00 PM**

Premium amount to be completed when issued..

**Page 1: Comment [D3]** **Eboni Warren (ga28462)** **5/16/2013 3:56:00 PM**

To be updated with frequency chosen by Exchange upon notification or when policy issued. If Exchange does not specify a frequency, it will be updated with frequency chosen by Dentegra.

**Page 1: Comment [D4]** **Courtney Rozear (ga24413)** **6/11/2013 11:11:00 AM**

The company's address is shown as variable in case it should need to be updated in the future.

## Header and footer changes

## Text Box changes

## Header and footer text box changes

## Footnote changes

## Endnote changes

# Attachment C
# Deductibles, Maximums and Policy Benefit Levels for Adult Benefits
# Dentegra Dental PPO
# Adult Basic

**Primary Enrollee: [Name]**

**Effective Date: [XXXXX]**

**Policy ID Number: [XXXX]**

**Premium:** [Per[D1] Enrollee:] [$ X[D2]XXX]

***Premiums are to be remitted [monthly]***[D3] ***to:***
Dentegra Insurance Company
[Street[D4] PO Box 660138
Dallas, TX 75266-0138]

You have a Calendar Year plan and Deductibles and Maximums will be based upon a Calendar Year. If you enroll mid-year due to a Qualifying Status Change, your Policy Year will be shorter than 12 months and will begin again on January 1.

| Deductibles & Maximums | |
|---|---|
| **Annual Deductible** | $50 per Enrollee each Calendar Year<br>$150 per family each Calendar Year |
| Deductibles waived for | Diagnostic & Preventive |
| **Annual Maximum** | $1,000 per Enrollee per Calendar Year |

| Policy Benefit Levels | | |
|---|---|---|
| **Dental Service Category** | **Dentegra PPO Provider**† | **Non-Dentegra Providers**† |
| Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for the following services: | | |
| **Diagnostic & Preventive** | 100% | 100% |
| **Basic Restorative** | 80% | 80% |

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

# Variable Form with Comments 6-10-13

**XIAtClo-TN-DIC (Redline 6-11-13).docx**

## Main document changes and comments

**Page 1: Comment [D1]** **Courtney Rozear (ga24413)** **4/11/2013 4:20:00 PM**

Rate tier variable to be completed when issued.

**Page 1: Comment [D2]** **Courtney Rozear (ga24413)** **4/11/2013 4:20:00 PM**

Premium amount to be completed when issued..

**Page 1: Comment [D3]** **Eboni Warren (ga28462)** **5/16/2013 3:57:00 PM**

To be updated with frequency chosen by Exchange upon notification or when policy issued. If Exchange does not specify a frequency, it will be updated with frequency chosen by Dentegra.

**Page 1: Comment [D4]** **Courtney Rozear (ga24413)** **6/11/2013 11:18:00 AM**

The company's address is shown as variable in case it should need to be updated in the future.

## Header and footer changes

## Text Box changes

## Header and footer text box changes

## Footnote changes

## Endnote changes

[State logo[D1]]


# Dentegra® Dental PPO

## Children's [Plan 70/85[D2]] + Adult [Basic/Preferred[D3]]

Combined Policy and Disclosure Form

Provided by:

Dentegra Insurance Company

variable text - highlight & delete if not needed
variable text - highlight & delete if not needed

**This Policy is conditionally renewable and may be terminated if all policies in this state are terminated.**

[dentegra[D4].com]

[State website and phone number[D5]]

# Policy

Your dental plan is underwritten by Dentegra® Insurance Company("Dentegra") and administered by Delta Dental Insurance Company. Dentegra will pay Benefits for covered dental services as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first installment of Premium. It takes effect on the Effective Date shown on Attachments A and C ("Attachment A" and "Attachment C") attached to this Policy. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where you live.

**READ YOUR POLICY AND ATTACHMENTS CAREFULLY**

**Ten 10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY**

Please read this Policy. If this Policy was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements or if you are not satisfied for any reason, you may return the Policy within ten (10) days after its delivery. Mail or deliver it to Dentegra's home office or to the agent through whom you purchased it. Any Premium paid will be refunded. This Policy will then be void from its start.

This Policy is signed for Dentegra, as of its Effective Date by:

Anthony S. Barth, Vice Chairman

## Table of Contents

# INTRODUCTION

We are pleased to welcome you to this individual Dentegra PPO dental plan. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

**Essential Health Benefit Plan –** The Essential Health Benefit Plan ("Pediatric Benefits") provides coverage to Eligible Pediatric Enrollees who are the Primary Enrollee's dependent children. Such children are eligible for Benefits under this Policy from birth to age 26. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulation.

**Supplemental Adult Benefit Plan –** The Adult Benefit Plan provides coverage for the Primary Enrollee and Eligible Dependents who are the Primary Enrollee's Spouse and children to age 26. Dependent children of the Primary Enrollee include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulation.

**NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.**

## Using This Policy

This Policy discloses the terms and conditions of the coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that "you" and "your" mean the Enrollees who are covered under this Policy. "We", "us" and "our" always refer to Dentegra.

## Contact Us

If you have any questions about your coverage that are not answered here, please visit our website at [dentegra[D6].com] or call our Customer Service Center. A Customer Service representative can answer questions you may have about obtaining dental care, help you locate a Dentegra Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at [877-280-4204] during regular business hours to obtain information about Enrollee Benefits, claim status or to speak to a Customer Service representative for assistance. If you prefer to write to us with your question(s) please mail your inquiry to the following address:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

## Identification Number

Please provide the Enrollee's ID number to your Provider whenever you receive dental services. The Enrollee ID number should be included on all claims submitted for payment. Identification cards are not required, but if you wish to have one you may obtain one by visiting our website at [dentegra.com].

# DEFINITIONS

The following are definitions of words that have special or technical meanings under this Policy.

**Accepted Fee:** the amount the attending Provider agrees to accept as payment in full for services rendered.

**Benefits (In-Network or Out-of-Network)**: the amounts that Dentegra will pay for dental services under this Policy. In-Network Benefits are those covered by this Policy and performed by a Dentegra Provider. Out-of-Network Benefits are those covered by this Policy but performed by a Non-Dentegra Provider.

**Benefit Year/Calendar Year:** the 12 months of the year from January 1 through December 31.

**Claim Form:** the standard form used to file a claim or request a Pre-Treatment Estimate.

**Dentegra PPO℠ Provider (Dentegra Provider):** a Provider who contracts with Dentegra and agrees to accept the Dentegra Provider's Contracted Fees as payment in full for services provided under this PPO plan.

**Dentegra PPO Provider's Contracted Fee (Dentegra Provider's Contracted Fee):** the fee for each Single Procedure that Dentegra Providers have contractually agreed to accept as payment in full for treating Enrollees.

**Effective Date**: The original date the plan starts. This date is given in Attachments A and C.

**Enrollee**: an Eligible Enrollee ("Primary Enrollee" or "Qualified Individual"), Eligible Dependent ("Dependent Enrollee") or Eligible Pediatric Enrollee ("Pediatric Enrollee") enrolled to receive Benefits.

**Exchange**: The Tennessee Federally Facilitated Marketplace Exchange.

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**Maximum Contract Allowance:** the reimbursement under the Enrollee's benefit plan against which Dentegra calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a Dentegra Provider is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee; or
- by a Non-Dentegra Provider is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee for a PPO Provider in the same geographic area.

**Non-Dentegra Provider:** a Provider who is not a Dentegra Provider and who is not contractually bound to abide by Dentegra's administrative guidelines.

**Open Enrollment Period:** the period of the year that the Exchange has established when the Eligible Enrollee may change coverage selections for the next Policy Year.

**Policy:** means this agreement between Dentegra and Primary Enrollee including the application if supplied by the Tennessee Federally Facilitated Marketplace Exchange, any attached amendments and appendices. This Policy constitutes the entire agreement between the parties.

**Policy Benefit Level:** the percentage of Maximum Contract Allowance that Dentegra will pay.

**Policy Term:** the period during which this Policy is in effect.

**Policy Year:** the 12 months starting on January 1st and each subsequent 12 month period thereafter coinciding with the Benefit Year. Policy Year can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change.

**Premium:** the amount payable as provided in Attachments A and C.

**Pre-Treatment Estimate:** an estimation of the allowable Benefits under this Policy for the services proposed, assuming the person is an eligible Enrollee.

**Procedure Code:** the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

**Program Allowance:** the amount determined by a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area.

**Provider:** a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

**Qualified Individual:** an individual determined by the Tennessee Federally Facilitated Marketplace Exchangeto be eligible to enroll through the Exchange.

**Qualifying Status Change:** a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- dependent child ceases to satisfy eligibility requirements;
- a court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by the Exchange.

**Single Procedure**: a dental procedure that is assigned a separate Procedure Code.

**Spouse**: a person related to or a partner of the Eligible Enrollee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where this Policy is issued and delivered; or
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Eligible Enrollee resides.

**Submitted Fee:** the amount that the Provider bills and enters on a claim for a specific procedure.

# OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how this dental plan works and how to make it work best for you.

## Benefits, Limitations and Exclusions

We will pay Benefits for the types of dental services as described in Attachment B Services, Limitations and Exclusions For Pediatric Benefits ("Attachment B") and Attachment B-1 Schedule of Covered Services and Limitations for Pediatric Benefits ("Attachment B-1");"; Attachment C Deductibles, Maximums and Policy Benefit Levels for Adult Benefits ("Attachment C"); Attachment D Services, Limitations and Exclusions for Adult Benefits ("Attachment D").

We will pay Benefits only for covered services. This Policy covers several categories of Benefits when a Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims shall be processed in accordance with our standard processing policies. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable

under this Policy. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

## Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown in the Attachments A and C, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled "Selecting Your Provider"). Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select Dentegra Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the section titled "Selecting Your Provider" for more information.

## Deductible

A deductible ("Deductible") is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts, if any, are listed in Attachments A and C. Deductibles apply to all covered dental services unless otherwise noted. Only the Provider's fees paid for covered Benefits will count toward the Deductible.

## Maximum Amount

A maximum amount ("Maximum Amount" or "Maximum") is the maximum dollar amount we will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. We will pay the Maximum Amount(s), if applicable, shown in Attachments A and C for Benefits under the Policy.

## Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under this Policy for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of this Policy when the treatment is actually performed. Pre-Treatment

Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

1) the date this Policy terminates;
2) the date the Enrollee's coverage ends; or
3) the date the Provider's agreement with Dentegra ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are covered and meet all the requirements of the plan at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

## GRIEVANCES AND APPEALS

If you have questions about any services received, we recommend that you first discuss the matter with your Provider. However, if you continue to have concerns, please call our Customer Service Center. You can also e-mail questions by accessing the "Contact Us" section of our website at [dentegra.com].

Grievancesregarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Dentegra, or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at [877-280-4204].

When you write, please include the name of the Enrollee, the ID number, and your telephone number on all correspondence. You should also include a copy of the Claim Form, claim statement, or other relevant information. Your claim statement will have an explanation of the claim review and any grievance process and time limits applicable to such process.

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, based upon lack of medical necessity. Any such denial will be based upon a determination by a Provider who holds a non-restricted license in the same or an appropriate specialty that typically manages the dental condition, procedure, or treatment under review. You and your Provider have at least 180 days after receiving a notice of denial to request a review by writing to Dentegra giving reasons why you believe the denial was wrong. You may also ask Dentegra to examine any additional information you include that may support your grievance.

Send your grievance to us at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

We will send you a written acknowledgment within 5 days upon receipt of your grievance. We will make a full and fair review within 30 days after we receive the grievance. We may ask for more documents if needed. We will send you a decision within 30 days. The review will take into account all comments, documents, records or

other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Policy, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

### Appeals

If you believe you need further review of your claim and/or your grievance, you may contact your state insurance regulatory agency.

## PROVISIONS REQUIRED BY LAW

### Entire Contract; Changes

This Policy, including the endorsements and the attached papers, constitutes the entire contract of insurance. No change to this Policy shall be valid until approved by our executive officer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

### Incontestability

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by you in the application for this Policy will be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 3-year period.

No claim for loss incurred or disability commencing after three (3) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss has existed prior to the Effective Date of this Policy.

### Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us when and as often as it may reasonably require during the pendency of a claim, in or near your community or residence. We will in every case hold such information and records confidential.

### Written Notice of Claim / Proof of Loss

We must be given written proof of loss within 15 months after the date of the loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required,

provided that the proof is filed as soon as reasonably possible. A notice of claim submitted by you, on your behalf, or on behalf of your beneficiary to us or to our authorized agent, with information sufficient to identify you will be considered notice of claim.

All written proof of loss must be given to us within 12 months of the termination of this Policy. Send your Notice of Claim/Proof of Loss to us at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30009]

## Claim Form

We will, within 20 days after receiving a notice of a claim, provide you or your Provider with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If we do not send you or your Provider a Claim Form within 15 days after you or your Provider gave us notice regarding a claim, the requirements for proof of loss outlined in the section "Written Notice of Claim/Proof of Loss" above will be deemed to have been complied with as long as you give us written proof that explains the type and the extent of the loss that you are making a claim for within the time established for filing proofs of loss. You may download a Claim Form from our website.

## Time of Payment

Claims payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be processed immediately after written proof of loss is received in the form required by the terms of this Policy. We will notify you and your Provider of any additional information needed to process the claim.

## To Whom Benefits Are Paid

It is not required that your services be provided by a specific dentist. Payment for services provided by a Dentegra Provider will be made directly to the dentist. Any other payments provided by the Policy will be made to you,unless you request in writing when filing a proof of claim that the payment be made directly to the dentist providing the services. All Benefits not paid to the Provider will be payable to you, the Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

## Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by you will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Policy, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the Policy at the same Premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the Premium to reflect your actual circumstances at time of application or to terminate your policy.

## Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Policy, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by this Policy.

## Conformity with State Laws

All legal questions about this Policy will be governed by the state of Tennessee where this Policy was entered into and is to be performed. Any part of this Policy which conflicts with the laws of Tennessee or federal law is hereby amended to conform to the minimum requirements of such laws.

## Third Party Administrator ("TPA")

Dentegra may use the services of a TPA, duly registered under applicable state law, to provide services under this Policy. Any TPA providing such services or receiving such information will enter into a separate Business Associate Agreement with Dentegra providing that the TPA shall meet HIPAA and HITECH requirements of the preservation of protected health information of Pediatric Enrollees.

# RENEWABLE – PREMIUM MAY CHANGE CONDITIONALLY:

The rate of the monthly Premiums will not be increased during the initial Policy Year. You will receive renewal information from the Exchange prior to any applicable open enrollment period. Provided Dentegra continues to make this policy available through the Exchange at the renewal period:

- you may elect to choose this Policy, which is subject to the applicable Premium through the Exchange for this plan at the time of renewal; and

- you may not have to make an election through the Exchange in subsequent open enrollment periods to continue coverage. The Eligible Enrollee should refer to the Exchange rules regarding automatic renewal of coverage.

## Reinstatement

If you do not pay the Premium within the time granted for payment, the Policy will be terminated as of the 31st day of the Premium grace period. See *Grace Period on Late Payments*.

If the Policy is terminated you may re-enroll in the program at the next Open Enrollment Period and the Deductible and maximum applicable to your program will start over. However, the Policy may be reinstated with no break in coverage provided the full Premium due is received by us within 90 days of the date of the past due Premium. The reinstated Policy will have the same rights as before your Policy lapsed, unless a change is made to the Policy in connection with the reinstatement. These changes, if any, will be sent to you for you to attach to the Policy.

## Payment Guidelines

We do not pay Dentegra Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Dentegra Provider, you are still responsible for the full cost. If the payment is denied because your Dentegra Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your Dentegra Provider that you were covered under a Dentegra Policy at the time you received the service, you may be responsible for the cost of that service.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, please contact us.

# PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment and any subsidy you receive, if applicable. Premiums are listed on Attachment A. An Eligible Enrollee is responsible for making Premium payments, paying Deductibles and Coinsurance and ensuring the Provider is aware of any other dental coverage he/she carries.
Each Premium is to be paid on or before its due date. A due date is the day following the last day of the period for which the preceding Premium was paid. You may pay your Premium [by[D7] visiting our website at [dentegra.com], or by mailing payment to the address below:

Dentegra Insurance Company
[P.O. Box 660138
Dallas, TX 75266-0138]

## Rate Guarantee

Your initial Premium rate is guaranteed for the first 12 months of your Policy, based upon the new enrollee rates in force at the time of your enrollment. The rate guarantee can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change.

No change in Premiums shall become effective within a Policy Term, unless Dentegra's liability is changed by law or regulation. Such a change may include a state and/or federal mandated change or a new or increased tax, assessment or fee imposed on the amounts payable to, or by, Dentegra under this Policy or any immediately preceding Policy between Dentegra and you. Dentegra would provide written notice to you, and this Policy shall thereby be modified on the date set forth in the notice.

## Changing Payment Options

Payment options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on your new billing period. You can change your payment option [by[D8] visiting our website at [dentegra.com], or by contacting our Customer Service Center toll-free at [877-280-4204].]

## Grace Period on Late Payments

If your Premium payment is not received by the first of the month, a grace period of 90 days will be granted. During the first 31 days of the grace period, the Policy shall continue in force. If premiums are not received by the[31st day of the grace period, claims will be placed on hold until the 90th day of the grace period. If premiums are not received by the 90th day of the grace period, your policy will be terminated as of the 31day of the grace period.

# ADDITIONAL DEFINITIONS FOR PEDIATRIC BENEFITS

**Deductible:** a dollar amount that a Pediatric Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits.

**Eligible Pediatric Enrollee**: a person who is considered to be a Qualified Individual by the Tennessee Federally Facilitated Marketplace Exchange and is eligible for Benefits as described in this Policy.

**Out-of-Pocket Maximum:** the maximum amount that a Pediatric Enrollee must satisfy for covered dental services during the Calendar Year provided a Dentegra Provider is used. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum has been met. The Out-of-Pocket Maximum for Dentegra Providers is shown in Attachment A.

**Patient Pays:** the financial obligation for a Pediatric Enrollee for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

# ELIGIBILITY AND ENROLLMENT FOR PEDIATRIC BENEFITS

## Eligibility Requirement

Eligible Pediatric Enrollees are Qualified Individuals as determined by the Exchange. A Qualified Individual must satisfy the Exchange's requirements regarding:

- Citizenship, status as a national, or otherwise lawfully present in the United States;
- Incarceration;
- Residency.

Eligible Pediatric Enrollees can be:

- Primary Enrollee's dependent children from birth to age 26 and include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of Spouse. Adopted children are eligible from the date of entry into the adoptive home or filing of the petition for adoption, whichever occurs first. If the child is in the custody of the state, coverage will begin at the date of entry of a final decree of adoption. Coverage for an adopted child will continue unless the petition is denied.

## Termination of Coverage

The Primary Enrollee has the right to terminate coverage under this Policy by sending Dentegra or the Exchange written notice of intent to terminate this Policy. The effective date of a requested termination will be fourteen days from the date of Dentegra's receipt of the request for termination. If coverage is termed because the Pediatric Enrollee is covered by Medicaid, the last day of coverage with Dentegra is the day before the new coverage is effective.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date.

The Primary Enrollee may keep this Policy in force by timely payment of the Premiums. However, Dentegra may terminate coverage due to:

- Enrollee no longer eligible through the Exchange;

- if termination is due to loss of eligibility through the Exchange, termination is effective the last day of the month following the month that the Exchange notifies you of lack of eligibility;

- non-payment of Premium:
  - if Premiums are not received by the 90th day of the Premium grace period, your policy will be terminated as of the 31st day of the Premium grace period. See *Grace Period on Late Payments*.
- Fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or the Enrollee applying for this coverage or filing a claim for Benefits;
- Enrollee has reached the age of 19;
- the Enrollee changes to a new pediatric dental policy for Enrollees through Tennessee Federally Facilitated Marketplace Exchange; or
- Dentegra ceasing to renew all Policies issued on this form to residents of the state where you live.

# SELECTING YOUR PROVIDER FOR PEDIATRIC BENEFITS

## Free Choice of Provider

We recognize that many factors affect the choice of Provider and therefore support your right to freedom of choice regarding your Provider. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Provider for your covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider.

**Remember, you enjoy the greatest benefits—including out-of-pocket savings—when you choose a Dentegra Provider.** To take full advantage of your Benefits, we highly recommend you verify a dentist's participation status with Dentegra with your dental office before each appointment. Review this section for an explanation of Dentegra payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

## Locating a Dentegra Provider

You may access information through our website at dentegra.com. You may also call our Customer Service Center and one of our representatives will assist you. We can provide you with information regarding a Provider's network, specialty and office location.

## Choosing a Dentegra Provider

Selecting a Dentegra Provider potentially allows the greatest reduction in Pediatric Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon. Also, the services received from a Dentegra Provider apply towards the Out-of-Pocket Maximum limiting a Pediatric Enrollee's out-of-pocket costs to the amount shown in Attachment A.

## Choosing a Non-Dentegra Provider

If a Provider is a Non-Dentegra Provider, the amount charged may be above that accepted by the Dentegra Providers, and Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply after the Out-of-Pocket Maximum is met. Costs incurred with a Non-Dentegra Provider do not count towards the Out-of-Pocket maximum. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

## Additional Obligations of Dentegra Providers:

- The Dentegra Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Dentegra after satisfaction of the Deductible and Coinsurance, and the Pediatric Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra PPO Provider's Contracted Fees.

## How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form, which most dental offices have available. Dentegra Providers will fill out and submit your claims paperwork for you. Some Non-Dentegra Providers may also provide this service upon your request. If you receive services from a Non-Dentegra Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Claim Form" for more information.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Dentegra Insurance Company

[P.O. Box 1850

Alpharetta, GA 30023-1850]

### Prior Authorizations for Medically Necessary Orthodontia

Orthodontic treatment is covered under Pediatric Benefits, which are shown in Attachments A, B and B-1, only when medically necessary as evidenced by a severe handicapping malocclusion, and prior authorization ("Prior Authorization") is required. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

## ADDITIONAL DEFINITIONS FOR ADULT BENEFITS

**Deductible:** a dollar amount that the Enrollee and/or the Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits.

**Eligible Dependent**: any of the dependents of an Eligible Enrollee who are eligible to enroll for Adult Benefits and who meet the conditions of eligibility.

**Eligible Enrollee**: any individual who meets the conditions of eligibility in this policy.

**Patient Pays:** Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

## ELIGIBILITY AND ENROLLMENT FOR ADULT BENEFITS

### Eligibility Requirement

Eligible Enrollees are Qualified Individuals as determined by the Exchange. A Qualified Individual must satisfy the Exchange's requirements regarding:

- citizenship, status as a national, or otherwise lawfully present in the United States;
- incarceration; or
- residency.

Dependent Enrollees can be:
Eligible Enrollee's Spouse and dependent children to age 26 and include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of Spouse.
A dependent unmarried child 26 years of age or older may continue eligibility if:

- he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;

- he or she is chiefly dependent on the Eligible Employee or Spouse for support; and
- proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Eligible Employee or Spouse for support because of a mental or physical disability that began before he or she reached the limiting age.

## Enrollment Grace Period

There is a period of 10 days from your Effective Date during which you may rescind this Policy and receive a full refund, provided you have not used Benefits under this Policy.

## Termination of Coverage

You have the right to terminate coverage under this Policy by sending Dentegra or the Exchange written notice of intent to terminate this Policy. The effective date of a requested termination will be fourteen days from the date of Dentegra's receipt of the request of termination. If coverage is termed because the Dependent Enrollee is covered by Medicaid, the last day of coverage with Dentegra is the day before the new coverage is effective.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date.

You may keep this Policy in force by timely payment of the Premiums. However, Dentegra may terminate coverage due to:

- Enrollee no longer eligible through the Exchange;
  - if termination is due to loss of eligibility through the Exchange, termination is effective the last day of the month following the month that the Exchange notifies you of lack of eligibility;
- non-payment of Premium:
  - if Premiums are not received by the 90th day of the Premium grace period, your policy will be terminated as of the 31st day of the Premium grace period. See *Grace Period on Late Payments*.
- Fraud or material misrepresentation made by or with the knowledge of the Enrollee applying for this coverage or filing a claim for Benefits;
- the Enrollee changes to a new individual dental policy for Enrollee through Tennessee Federally Facilitated Marketplace Exchange; or
- Dentegra ceasing to renew all Policies issued on this form to residents of the state where you live.

# SELECTING YOUR PROVIDER FOR ADULT BENEFITS

## Free Choice of Provider

We recognize that many factors affect the choice of Provider and therefore support your right to freedom of choice regarding your Provider. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Provider for your covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider.

**Remember, you enjoy the greatest benefits—including out-of-pocket savings—when you choose a Dentegra Provider.** To take full advantage of your Benefits, we highly recommend you verify a dentist's participation status with your dental office before each appointment. Review the section titled "Selecting Your Provider" for an explanation of Dentegra payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

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## Choosing a Dentegra Provider

Selecting a Dentegra Provider potentially allows the greatest reduction in the Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon.

## Choosing a Non-Dentegra Provider

If a Provider is a Non-Dentegra Provider, the amount charged to Enrollees may be above that accepted by the Dentegra Providers, and Enrollees will still be responsible for coinsurance and balance billed amounts. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

## Additional Obligations of Dentegra Providers:

- The Dentegra Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Dentegra after satisfaction of the Deductible and Coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra PPO Contracted Fees.

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Claims for Benefits must be filed on a standard Claim Form, which most dental offices have available. Dentegra Providers will fill out and submit your claims paperwork for you. Some Non-Dentegra Providers may also provide this service upon your request. If you receive services from a Non-Dentegra Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Claim Form" for more information.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

# NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice is required by law to tell you how Dentegra protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Dentegra receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Dentegra program, and we will notify you of how you can receive a copy of this notice every three years.

## Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Dentegra in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate. These affiliates have also implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

**Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations**

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.

  *For example, Dentegra may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment.

  *For example, Dentegra may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations.

  *For example, Dentegra may use and disclose your PHI to review the quality of care provided by our network of providers.*

**Disclosures Without an Authorization**

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Dentegra may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

**Disclosures Dentegra Makes With Your Authorization**

Dentegra will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Dentegra or by a person requesting your PHI from Dentegra.

**Your Rights Regarding PHI**

**You have the right to request an inspection of and obtain a copy of your PHI.** You may access your PHI by contacting the appropriate Dentegra office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Dentegra may charge a reasonable fee for providing you copies of your PHI. Dentegra will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Dentegra to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Dentegra does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

**You have the right to request a restriction of your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

**You have the right to correct or update your PHI.** This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

**You have the right to request or receive confidential communications from us by alternative means or at a different address.** We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

**You have the right to get this notice by email.** You have the right to get a copy of this notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice.

**Complaints**

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Dentegra has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

**Contact**

You may contact the privacy office at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Dentegra Insurance Company
c/o Office of Compliance
[P.O. Box 1850
Alpharetta, GA 30023-1850]

Phone: [877-280-4204]

**This notice is effective on and after August 1, 2012.**

# EMPLOYEE NOTICE

## NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

### COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

### EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
(2) the insurer was not authorized to do business in this state;
(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) any policy of reinsurance (unless an assumption certificate was issued);
(3) interest rate yields that exceed an average rate;
(4) dividends;
(5) credits given in connection with the administration of a policy by a group contract holder;
(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
(7) unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

## LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**Tennessee Life and Health Insurance Guaranty Association 150 3rd Avenue South, Suite 1600 Nashville, TN 37201**

**Tennessee Department of Commerce and Insurance 500 James Robertson Parkway Nashville,Tennessee 37243**

# Variable Form with Comments 6-10-13

**XIP-TN-DIC (Clean 6-11-13).doc [Compatibility Mode]**

## Main document changes and comments

**Page i: Comment [D1]** **Courtney Rozear (ga24413)** **6/11/2013 11:34:00 AM**

State logo will be inserted here if required.

**Page i: Comment [D2]** **Courtney Rozear (ga24413)** **6/11/2013 11:34:00 AM**

This field will be updated with the plan name to be issued.

**Page i: Comment [D3]** **Courtney Rozear (ga24413)** **6/11/2013 11:34:00 AM**

This field will be updated with the plan name to be issued.

**Page i: Comment [D4]** **Courtney Rozear (ga24413)** **6/11/2013 11:34:00 AM**

The website address is filed as variable in case in needs to be updated in the future.

**Page i: Comment [D5]** **Courtney Rozear (ga24413)** **6/11/2013 11:34:00 AM**

This informaiton is filed as variable.

**Page 1: Comment [D6]** **Courtney Rozear (ga24413)** **4/9/2013 2:58:00 PM**

The company's address, website and phone numbers are shown as variable throughout this document in case those items should need to be updated in the future.

**Page 10: Comment [D7]** **Courtney Rozear (ga24413)** **4/9/2013 3:00:00 PM**

Dentegra will include payment via its website when available. It is Dentegra's intent to have this capability available by January 2014.

**Page 11: Comment [D8]** **Courtney Rozear (ga24413)** **4/9/2013 3:00:00 PM**

Dentegra will include payment via its website when available. It is Dentegra intent to have this capability available by January 2014.

## Header and footer changes

## Text Box changes

## Header and footer text box changes

## Footnote changes

# Variable Form with Comments 6-10-13

**Endnote changes**

DENTEGRA Insurance Company

www.dentegra.com

# Readability Certification

As an authorized representative of the company, we have reviewed the enclosed policy forms and certify that, to the best of our knowledge and belief, each form submitted meets your state's minimum statutory requirements relating to the readability of said forms.

| Dick Aracich | Vice President, Sales |
|---|---|
| Name | Title |
| Signature | 6-11-13 |
| | Date |

**Corporate Headquarters**
100 First Street San Francisco CA 94105
Telephone 866-238-1580